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The JOURNAL

OF THE INDIANA STATE
MEDICAL ASSOCIATION

July 1977 • Vol.70 • No.7



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SMA ANNUAL MEETING • October 23-26 • Indianapolis

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Valium (diazepam) is a benzodiazepine with a character all its own.

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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MEDICAL MUSEUM NOTES



Dr. James Gosman, who, as president of the Indiana State Medical Association, appointed the Association's first Medical History Committee in early 1973, has recently performed another meritorious service in the preservation of Indiana's medical history. On May 19, Dr. Gosman, who conceived the idea,

presided on the occasion of the reunion of persons associated with Norways Sanatorium. Dr. Phillip Reed, now of St. Petersburg, Fla., was guest of honor.

Norways Sanatorium, a private hospital for the treatment of nervous and mental disorders, was located on the near eastside of Indianapolis and was in operation from 1898 to 1957. Named for the Norway maples, which were responsible for the park-like atmosphere of its grounds, the building and trees have long since been destroyed and the area replaced by a shopping center.

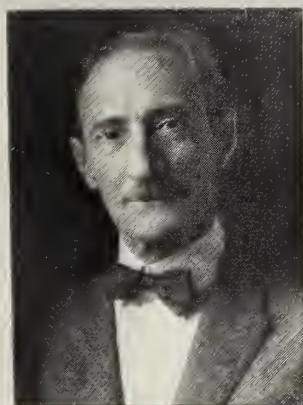
The sanatorium was founded by Dr. Albert Sterne, who taught neurology and psychiatry to medical students of the old Central College of Physicians and Surgeons, and later to students of Indiana University School of Medicine, from the amphitheater of the Old Pathology Building.

Dr. Sterne was later assisted in operating Norways Sanatorium by Dr. Larue Carter (for whom the State Hospital is named). Dr. Carter also taught the students of the Indiana University School of Medicine from the amphitheater of the Old Pathology Building.

For many years a golden frame containing the photographs of Dr. Sterne and Dr. Carter, together with a brief history of Norways, hung over the fireplace mantel at Norways.

Dr. Phillip Reed, son-in-law of Dr. Sterne, gave an impromptu talk at the reunion, telling the history of Norways and many anecdotes of people associated with it. He climaxed his talk with a presentation of the framed pair of photographs of Dr. Sterne and Dr. Carter to the Museum.

CHARLES A. BONSETT, M.D.
6133 E. 54th Place
Indianapolis 46226



Dr. Albert Eugene Sterne
1856 - 1931

Professor of Neurology and Psychiatry,
Indiana University School of Medicine.
Chief of Staff Surgeon General Indiana, 1911-15.
Member Committee National Defense,
Medical Division World War I.
Past President Mississippi Valley
Medical Association.

Norways Sanatorium

was established in 1898 by Dr. Albert E. Sterne who brought advanced methods of diagnosis and treatment into use here from his training abroad. Some of the better known techniques were introduced as follows: X-ray studies, 1899; examination of nerve tissue, 1900; and brain surgery, 1906. Upon Dr. Sterne's death his associate Dr. Larue D. Carter succeeded him, sponsoring the first known use in Indiana of the following treatments: Insulin, 1937; Maltorial, 1938; and Electrotonic, 1940. The foregoing examples are representative of the high standards of medical care which will endure here as a memorial to these two specialists in Neurology and Psychiatry.



Dr. Larue Deven Carter
1880 - 1956

Professor of Neurology and Psychiatry,
Indiana University School of Medicine.
Colonel, Medical Corps, World War I.
Colonel, Reserve Medical Corps, Indiana
Liaison Officer to Fifth Service Command
World War II.
Past President Indianapolis Medical Society.

Letters

To the editor:

I am convinced that lives now needlessly lost to severe systemic reactions to insect sting could be saved by a greater awareness of both the possibilities of such fatal responses and of the existence of insect sting kits to be employed as emergency first aid measures to stave off anaphylaxis. Because of this conviction, I am in the process of collecting and collating data on the incidence of such fatalities. I am especially interested in the time lapse between sting and death, although other information would also be greatly appreciated such as the following: Time sequence of symptoms, previous reactions victim may have had to insect stings, whether and what medication the victim may have had on hand at the time of the incident, the type of insect, if known, how many stings the victim may have suffered, and an estimation of whether a physician or hospital emergency room could have been reached in time to avoid a fatal outcome.

Thank you.

CLAUDE A. FRAZIER, M.D.
4-C Doctors Park
Asheville, N.C. 28801

To members of I.S.M.A.:

Two "open" claim files for participants under our ISMA disability insurance plan demonstrate the worth of this Income Protection Plan.

One ongoing claim has resulted thus far in insurance payments of \$10,400 and in another case \$7,360 has been paid.

Selected at random from the files of our insurance administrator, these examples are far from unusual.

In other words, ISMA members face periods of sickness and disability from accident. Usually they must rely on their own financial resources to meet continuing family and personal expenses at a time when personal income may be drastically reduced or non-existent.

Isn't it good planning to substitute a known expense, such as the insurance premium, for an unknown disability income loss?

A 45-year old physician, for example, may have \$1,000 monthly disability income benefits for \$105.50 semiannually. The income will be paid monthly for a maximum of 5 years after a 30-day elimination period.

Total payments for this member might reach \$60,000. How many could afford this out of their own resources during a period of disability?

Recently the membership received letters and brochures about this program, giving a full schedule of benefits and premiums. The new monthly income limit is \$2,000 under our ISMA plan.

ISMA members are urged to review this material and, after considering individual requirements, to submit their application. It may be mailed to ISMA or to the undersigned.

Really, it's peace of mind we are talking about!

J. RUSSELL TOWNSEND, JR.,

Plans Administrator

705 Board of Trade Bldg.

INDIANAPOLIS 46204

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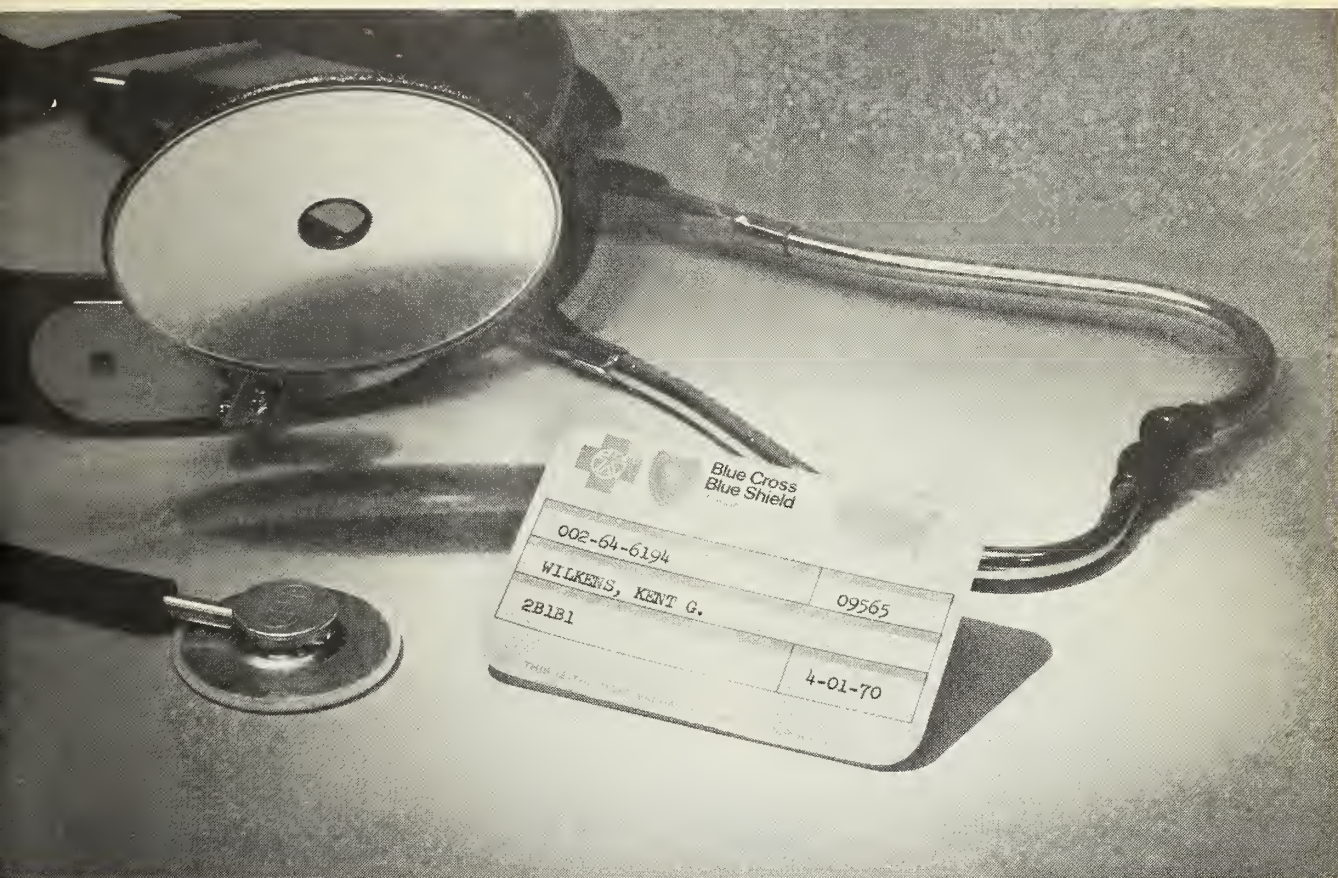
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Medicine Grand Rounds—Indiana University
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Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Romsey, M.D., Editor, 3935 N. Meridian St., Indianapolis 46208. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

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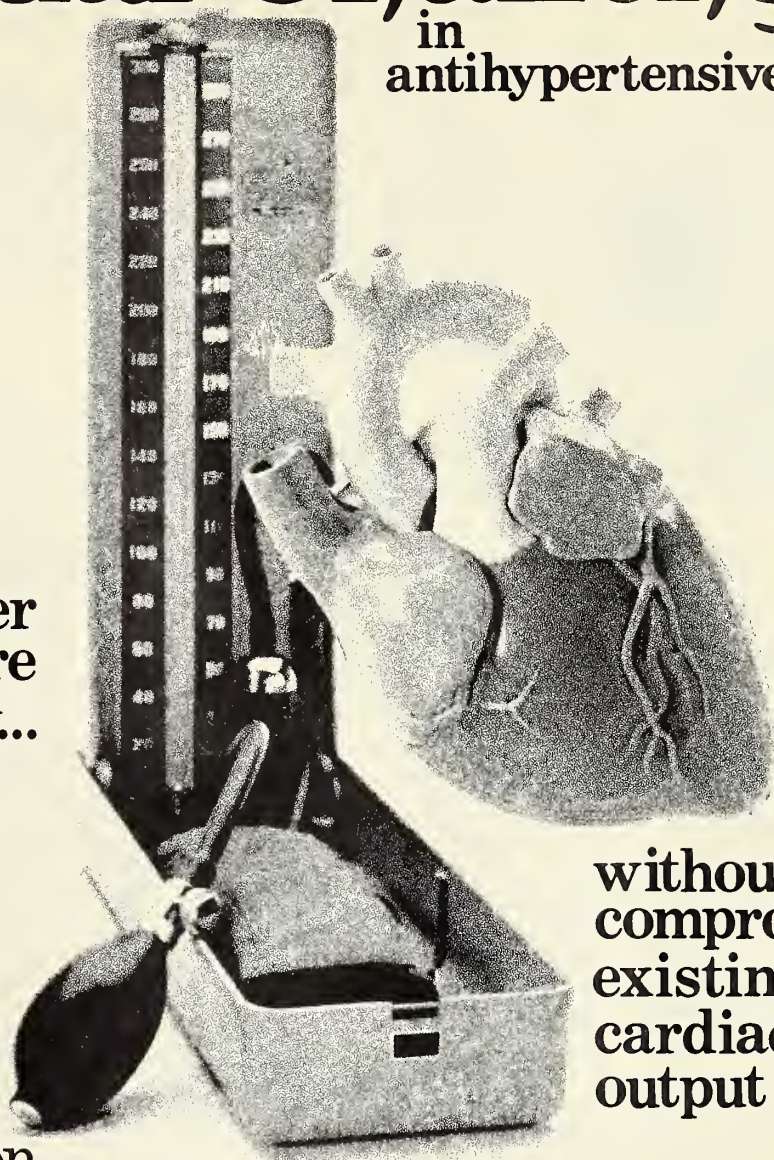
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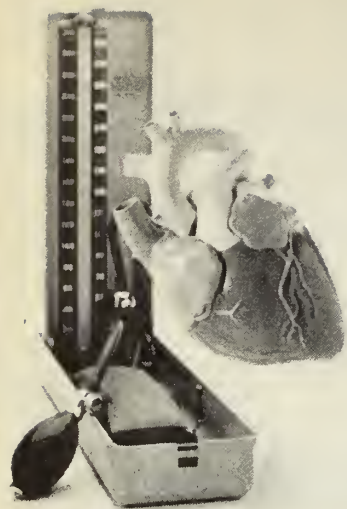
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For a brief summary of prescribing information, please see following page.

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helps lower
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effectively...
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direct effect on
cardiac function—
cardiac output is
usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness; symptoms of cerebrovascular insufficiency: paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatulence, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000. Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07 (707)



This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

THE HOUSE HAS MOVED SWIFTLY to consider the Administration's sweeping Hospital Cost Containment program that has drawn the wrath of hospitals and physicians.

Joint hearings by the health subcommittees of the House Ways and Means and House Commerce Committees are in progress. Devising a bill, however, will take a long time and it could look much different than what the Administration is asking.

Rep. Paul Rogers (D-Fla.), chairman of the Commerce Health Subcommittee, said in introducing the Administration's bill that "we must proceed with care in this area." The influential lawmaker questioned whether "any system for controlling the increases in costs of hospital care will work over the long run unless . . . an incentive system is present" to encourage hospitals to hold down increases.

Rep. Dan Rostenkowski (D-Ill.), chairman of the Ways and Means Health Panel, who also dropped the bill in the hopper, told the House that "I am sure there will be serious objections raised to the President's proposal. Some will argue that a cost containment program applying only to hospitals unfairly singles them out and will do harm to the quality and availability of necessary care."

The House hearings so far have met an almost solid block of opposition from health providers as well as tepid endorsement from labor.

Even more foreboding from the Administration's standpoint is the fact that no member of the health subcommittees of the House Ways and Means and House Commerce Committees took the role of all-out champion of the Administration proposal during the three days of joint hearings. Some lawmakers directed criticism at hospitals and physicians in connection with the inflation in health care costs, but none of the Congressmen seemed enamored of the Administration's scheme for dealing with the problem.

The American Medical Association told the subcommittees the legislation singles out one segment in the economy for the imposition of special controls by limiting inpatient revenues of most hospitals to approximately a 9% increase annually. This is similar to the "opprobrious retention" of the "now discredited" wage-price controls to the health field in Phase IV of the economic stabilization program while removing controls from the rest of the economy, said Raymond T. Holden, M.D., chairman of the AMA Board of Trustees.

"The AMA is concerned over the impact that this legislation would have on the quality and availability of hospital care for the American people," said Dr. Holden. "It seems inescapable to us that the 'cap' on spending will result in second-rate care, and some care may simply become unavailable for many people."

The American Hospital Association, the Federation of American Hospitals, the American Protestant Hospital Asso-

ciation, the Catholic Hospital Association, and the Association of American Medical Colleges were among other health organizations that inveighed against the Administration plan. The Health Insurance Association of America gave "somewhat qualified support" with many reservations. The Blue Cross Association proposed a national moratorium on new plant capital expenditures, but "we seriously question" whether the "cap" plan would be "effective or equitable."

THE AMERICAN MEDICAL ASSOCIATION HAS TOLD the House Commerce Subcommittee on Oversight and Investigations that a second opinion "is just that and nothing more—an opinion which is, by definition, subjective and it can never be anything other than that," asserted James H. Sammons, M.D., AMA executive vice president.

The Subcommittee, headed by Rep. John Moss (D-Calif.), has engaged in a running controversy with medical groups since it issued a report a year ago implying there are many thousands of deaths due to unnecessary surgery. The issue has stirred calls on Capitol Hill for required second opinions and suggestions for establishing criteria for determining under Medicare and Medicaid the necessity of surgical procedures and which should be elective.

Dr. Sammons said "such an approach is contrary to sound medical practice." The AMA has no desire to protect the guilty and the incompetent, he asserted. The question of what is necessary or unnecessary, what is wrong, must be decided at the peer review level, Dr. Sammons said. "I am certain in my own mind that there is surgery performed every day that I would not personally agree with, but that is true of all aspects of every profession," said the AMA official. The number of such cases would be very small, he stressed.

THE THREAT OF FEDERAL TRADE COMMISSION direct jurisdiction over non-profit associations such as medical organizations has been blocked in Congress.

The House Commerce Committee by voice vote rejected the proposal. The Senate Commerce Committee approved a bill that had been stripped of a similar provision following subcommittee adoption. The non-profit association provision was part of a broader measure extending FTC powers and penalties that was okayed by both committees.

At present, the FTC, which is currently engaged in a wide-range of cases against medical-health groups including the AMA, must prove in court that it has jurisdiction over non-profit association on grounds the challenged activity resembles a commercial activity and operates for the economic benefit of the members of a non-profit association.

This has proved a legal obstacle to some FTC actions against non-profit associations in the past. The FTC had urged Congress to adopt the plan. However, the AMA and a host of other non-profit associations argued that the new powers would give the federal agency more authority than

Continued on page 567

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

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DELEGATES TO THE AMA

Terms expire December 31, 1977:

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Alternates: Thomas C. Tyrrell, Hammond; Marvin E. Priddy, Fort Wayne.


Terms expire December 31, 1978:

Delegates: James A. Harshman, Kokomo; Malcolm O. Scomhorn, Pittsboro; Ross L. Egger, Daleville.

Alternates: George Lukemeyer, Indianapolis; Everett Bickers, Floyd's Knobs; Gilbert M. Wilhelmus, Evansville.

1976-77 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	James A. Marvel, Evansville	Forrest F. Radcliff, Evansville	
2.	Hugh S. Ramsey, Bloomington	James P. Beck, Washington	
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4.	Larry Williams, Madison	Gerald T. Bawen, Lawrenceburg	
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9.	Paul Van Kirk, W. Lafayette	David L. Evans, Lafayette	
10.	James R. Brown, Valparaiso	Barron M. F. Polmer, Hammond	
11.	William Dannacher, Wabash	Fred Poehler, La Fontaine	
12.	Thomas A. Felger, Fort Wayne	John Paul Smith, Fort Wayne	Sept. 8, Fort Wayne
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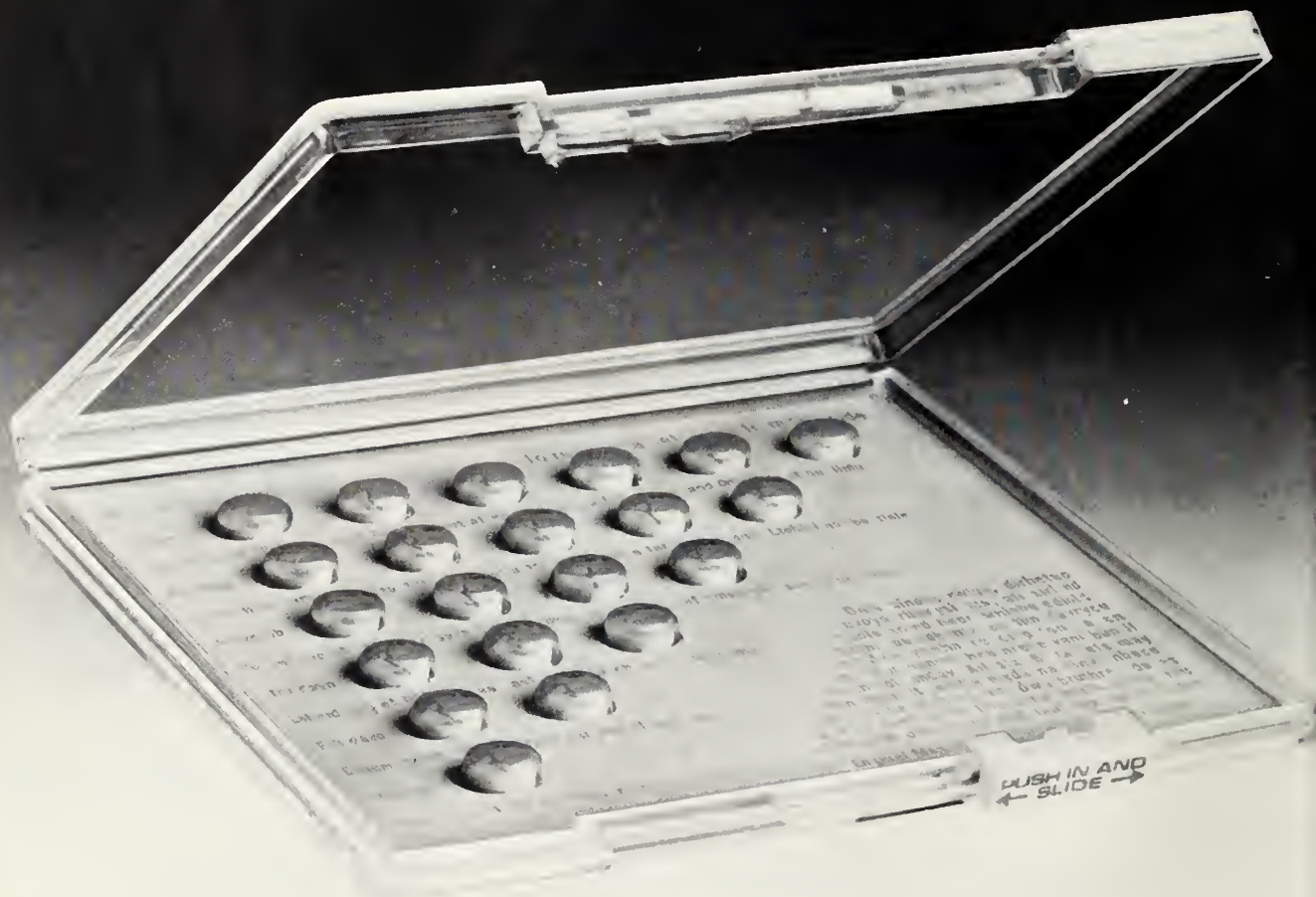
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Congress had intended as an instrument against unfair business practices. The effect would have been to lump all activities of non-profit groups in the same legal boat as those of commercial businesses.

Despite its victory in blocking the inclusion of non-profit organizations under the same flag as commercial business, the AMA and others will support a floor amendment to block a committee-passed section of the legislation that would authorize class action suits (by private individuals) for violations of FTC rules.

THE AMERICAN MEDICAL ASSOCIATION and the American Hospital Association were criticized by Health, Education, and Welfare Secretary Joseph Califano for opposing the Administration's hospital cost containment plan.

Califano said the two organizations "have opposed virtually every progressive step in the health care area, every step for the government to become the catalyst and further expand service to the poor and needy."

Califano also told the *Washington Post* that hospitals should take a tougher line negotiating with hospital-based specialists who "get a percentage of the gross" income of their departments. "That's like the entertainment business," he said. "This is not the entertainment business."

SECRETARY CALIFANO HAS EXPRESSED "DEEP REGRET" to the AMA at "the significant number of errors" in the March 12 publication of names of health providers whose 1975 Medicare income surpassed \$100,000.

"I am deeply distressed at the number of errors, and I regret any embarrassment that may have been caused to any of your individual members," Califano said in a letter to James H. Sammons, M.D., AMA executive vice president.

Following the original publication of the list, the AMA and some state medical societies checked 208 of the 407 physicians on the list and found an error rate of 64.9%. Dr. Sammons urged an apology for the mistakes.

Califano said he has asked Robert Derzon, administrator-designate of the new Health Care Financing Administration, to review the entire matter with the view toward taking whatever actions are necessary to prevent a situation like this from arising again.

THE INFLUENTIAL AND LIBERAL *Washington Post*, commenting on President Carter's remarks before the United Automobile Workers annual meeting concerning delay of national health insurance, said in an editorial that the President's declaration that the government cannot afford to do everything was "dead right."

Said the Post:

"We also think it would be the final and complete ruination of liberalism—whatever that may mean anymore—if its self-professed minions refused to face up to the difficult domestic choices and just kept on asking for it all."

Asked the *Post* in an editorial that will have repercussions in the nation's capital:

"Is the intervention of government in peoples' lives, even for a benign purpose, always so benign in the way it works? Have we not learned that there can be a streak of ugly authoritarianism in even the most well-intended government programs? Can liberals afford to be as contemptuous as they traditionally have been of those who regard inflation as the principal public enemy?"

The editorial said these are questions serious-minded Democrats should be thinking about now—"not whether it is illiberal of Jimmy Carter to have delayed the prospective introduction of national health insurance until early in 1978."



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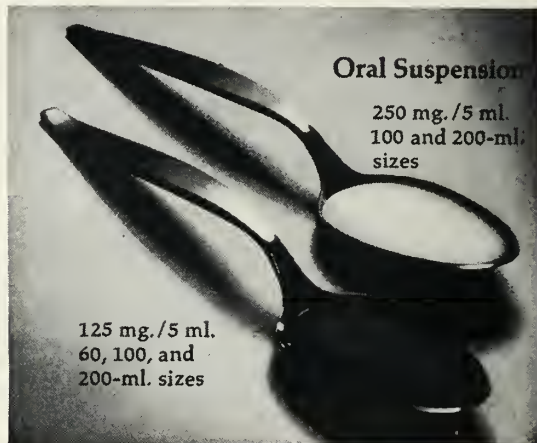
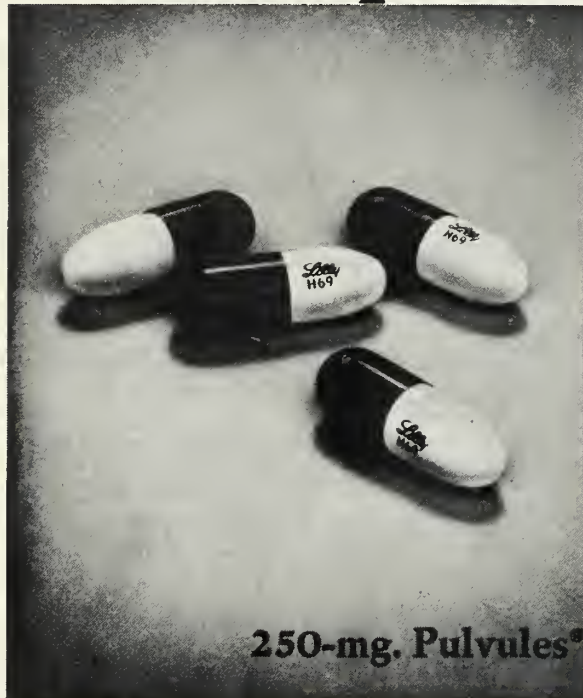
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Hypertension—I

The Silent, Endemic Disease—Hypertension

MYRON H. WEINBERGER, M.D.
Indianapolis

RECENT national health surveys have disclosed that blood pressure in excess of 140/90 is observed in approximately 20% of adult Americans. Of these, approximately half have blood pressures greater than 160/95. Thus, it is apparent that blood pressure levels higher than traditionally accepted normal values are an endemic medical problem in adult Americans today. It is useful to consider the significance and implications of blood pressure readings in addressing this problem. Certainly, blood pressure is a continuous variable with no clear-cut demarcation between normal and abnormal. As such, it demonstrates a bell-shaped distribution and is subject to considerable variation within an individual.

The significance of elevated blood pressure has been recently emphasized in several ways. A cooperative study of adult American males conducted by the Veterans Administration Hospitals has shown a direct relationship between the degree and duration of blood pressure elevation and cardiovascular morbidity and mortality. In addition, epidemiologic studies heralded

by the long-standing, extensive Framingham Study, have pointed out a close association between elevated blood pressure and prognostic significance in terms of stroke, heart attack and kidney failure. Finally, the significance of even mildly elevated blood pressure can be immediately appreciated by reviewing life insurance rating tables, since actuarial statistics indicate that people with even mild elevations of blood pressure are less likely to live long enough to make the normal number of life insurance premium payments and therefore are charged more for insurance. For example, a 35-year-old male with a blood pressure of 120/80 can currently be predicted to live to age 72. If his blood pressure is 130/90, a 4-year reduction in life expectancy is predicted. With a blood pressure of 140/95, he can be expected to live to be 63, and, with a blood pressure of 150/100, a 16-year reduction in life expectancy is predicted. Thus, even mild elevation in blood pressure is associated with decreased longevity.

The significance of hypertension as a medical problem is further borne out by examining the impact of antihypertensive therapy. In the previously mentioned Veterans Administration Cooperative Study, a significant decrease in morbidity and mortality due to cardiovascular-

related events was demonstrated in hypertensives with diastolic blood pressure greater than 105 mm Hg who were treated with blood pressure lowering agents and achieved reduction in blood pressure. Their cohorts who were treated with placebos had no decrease in blood pressure. In fact, the striking difference in morbidity and mortality between treated and untreated groups forced the investigators to terminate the project before completion of the proposed five-year study, because they could not morally justify continued non-treatment of the control group. In addition, national health statistics have recently demonstrated a decline in the cardiovascular death rate which appears to be most marked over the past five years, a period coinciding with a dramatic increase in professional concern for the problem of hypertension, its improved detection and treatment, the availability of new and effective antihypertensive agents in the medical armamentarium, and a twofold increase in patient visits to a physician for hypertension. Recent studies indicate that more than 90% of the uncomplicated hypertensive population can achieve blood pressure control with administration of a relatively simple therapeutic regimen. Increased awareness about hypertension on the part of the lay public,

Dr. Weinberger is professor of medicine and director of the Specialized Center of Research (SCOR) in Hypertension.

From the Indiana University School of Medicine, Indianapolis 46202.

increased concern regarding the preventable consequences of hypertension by the medical profession, and improvement in efficacious antihypertensive therapy by the pharmaceutical industry have markedly enhanced our ability to effectively detect and treat hypertension. It is not surprising that inroads have been made upon cardiovascular morbidity and mortality by this increased detection and effective treatment of hypertension. However, recent surveys indicate that only 12-15% of the adult hypertensive American population have achieved adequate control of blood pressure. Thus, it is apparent that a better job can and must be done.

There are several fundamental challenges that remain in attacking hypertension today. The first is detection. Because of its asymptomatic nature, approximately 50% of the adult American hypertensives are completely unaware of their elevated blood pressure. This observation has led to a plethora of activities by well-meaning national and civic groups to conduct screening programs for the purpose of detecting the asymptomatic hypertensive. The truth of the matter is, 75% of the American people visit their physician once a year. Thus, it would appear that the physician's office is the most efficient place to conduct preliminary screening for hypertension. Furthermore, since community screening programs do not usually include any effort or commitment toward ensuring the patient's entry into a medical care system or any mechanism for follow-up of newly detected hypertensives, the physician's office becomes an even better place for the screening operation. It would appear that the routine measurement of blood pressure in every patient coming into a physician's office or hospital would be an excellent way to detect the asymptomatic, unknown hypertensive.

Routine measurement of blood pressure in the physician's office can most efficiently be done by an office nurse or trained receptionist. It can easily be made part of the

intake process. The person measuring blood pressure should be aware of the need to choose appropriately sized sphygmomanometer cuff widths in proportion to the subject's arm, since using a small cuff on a large arm will give artificial elevation in blood pressure. Both pediatric and thigh-size cuffs should be available in addition to the standard cuff. A mercury manometer is ideal; alternatively, aneroid manometers are usually accurate if periodically calibrated against a mercury manometer and if the gauge is checked to see that the needle returns precisely to zero upon deflation. In most instances the use of the fifth Korotkoff phase (disappearance of sound) appears to be the best way of estimating diastolic pressure, eliminating subjectivity and correlating well with intra-arterial diastolic pressure.

Education of Patient Vital

After detection, the next major problem is one of education regarding the significance of elevated blood pressure. Slight elevations of blood pressure are frequently disregarded as being simply due to nervousness or overweight. While these factors may influence blood pressure, they do not usually cause it to be abnormal and current data on adult Americans indicate that the finding of one elevated blood pressure strongly correlates with subsequent sustained elevation of blood pressure and progressive morbidity and mortality due to cardiovascular-related events. Certainly three or more blood pressure readings which are above acceptable limits should be documented before embarkation on a therapeutic program with its lifelong commitments. Thus, education of the patient about the seriousness of mild elevations of blood pressure and the need for systematic follow-up and, if necessary, treatment cannot be overemphasized.

Antihypertensive therapy has changed markedly with the availability of new drugs and with our improved understanding of the pathophysiology and pharmacology of hypertension. The plethora of new drugs has sometimes led to

confusion about how to treat hypertension, with the result that patients are tried on a variety of agents before one acceptable regimen is found. The patient needs to be told that changes in medication may be necessary to adequately control his blood pressure with a minimum of expense and side effects. Subsequent articles in this series will be directed toward an understanding of how the various antihypertensive drugs work, and on whom and how they should be used. Strategies for simplified therapeutic regimens which can be expected to be effective in a majority of ambulatory hypertensives will also be discussed.

The final challenge in hypertension is that of therapeutic compliance. It is difficult for asymptomatic people to accept the need to take medication which may be expensive, involve multiple doses and be associated with irritating side effects, for a disorder which causes them no symptoms. Unlike the patient with an uncomfortable or visible medical illness, such as a peptic ulcer or skin infection, the hypertensive is rarely symptomatic until the late stages of his disorder or until a complication has occurred. Thus, the importance of prophylactic therapy to prevent the occurrence of symptoms and complications at the time when hypertension is first discovered and is relatively asymptomatic needs to be emphasized. This educational process does not need to involve a great deal of the physician's time, since it can be effectively administered in the form of printed material and by trained paraprofessionals, such as the office nurse or receptionist.

National health surveys have indicated several major reasons for failure to control blood pressure. One of these is that no follow-up appointment for the patient is made that will permit the physician to evaluate compliance and long-term results. This leads the patient to assume that he no longer has high blood pressure or that he no longer

needs medication. This obviously is an educational problem which must be dealt with at the initiation of antihypertensive therapy, when the patient should be told that the disorder is likely to be a lifelong problem requiring lifelong medical therapy. Paraprofessionals can be used to measure blood pressure periodically, thus reserving the valuable practitioner's time to deal with appropriate medical problems and the uncontrolled hypertensive, rather than routinely seeing adequately controlled hypertensives who are doing well on their therapeutic regimen. Other reasons for non-compliance previously mentioned include the costs and side effects of antihypertensive therapy. Current knowledge indicates that these problems can be minimized by an increased physician and paraprofessional awareness of these potential factors in prescribing antihypertensive medication and the utilization of a step-care approach to treatment.

Future articles in the projected series on hypertension will include: When, why, and how to treat the hypertensive, actions and interactions of antihypertensive drugs, the comprehensive diagnostic evaluation of hypertension, estrogen-induced hypertension, primary aldosteronism, renovascular hypertension, pheochromocytoma, malignant hypertension, hypertension in childhood, hypertension in pregnancy, hypertension in renal failure, hypertension and the cardiovascular system, specific antihypertensive therapy based on renin profiling, newer antihypertensive drugs, patient compliance in hypertension and the role of the nurse in the evaluation and treatment of hypertension.

This series is being prepared by physicians at the Specialized Center of Research (SCOR) in Hypertension at the Indiana University School of Medicine, a group of 30 medical professionals with a primary interest in the broad problem

of hypertension. This multidisciplinary Center includes expertise in biochemistry, physiology, pharmacology, internal medicine, endocrinology, cardiology, nephrology, obstetrics and gynecology, urology, radiology, nuclear medicine, medical genetics, nursing and sociology. The clinical activities of the Center are directed toward the development and implementation of new diagnostic and therapeutic approaches to hypertension. Previous studies at Indiana have led to new techniques which are currently in wide use in hypertension and will be discussed in detail in subsequent articles. Physicians at the Hypertension Center have new, experimental antihypertensive agents which are in clinical trial for severe hypertensives refractory to conventional multiple drug therapy. Thus, the Center and its investigators provide a resource for physicians who have specific problems or questions in dealing with various aspects of hypertension and its challenges. ◀



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AIR FORCE... A Great Way of Life



Medicine Grand Rounds—Indiana University School of Medicine

Extracted from the Grand Rounds presentation of Jan. 12, 1977, to the faculty, house officers and students of the Department of Medicine, Indiana University School of Medicine.

Hemophilia

GRACE JORDISON BOXER, M.D.
Indianapolis

THE hemophilias are the most important inherited clotting disorders. They include hemophilia A, or classical hemophilia, and hemophilia B, or Christmas disease. In hemophilia A there is a functional deficiency of factor VIII, and in hemophilia B there is a functional deficiency of factor IX. In both cases the functional deficiency is due to a molecular derangement, and in a few, but not most, cases of factor IX, a lack of the involved factor. Both diseases have similar clinical manifestations and a similar mode of inheritance, but the differentiation is important for therapeutic reasons. The prevalence of hemophilia of all degrees of severity is estimated to be about 26 per 100,000 males, making hemophilia a not uncommon disease.¹ Approximately 80% of the hemophiliacs have hemophilia A and the remaining 20% have hemophilia B.

The diagnosis of severe or moderately severe hemophilia should be suspected from the history. Laboratory tests serve to confirm or rule out the clinical suspicion and to define the abnormality precisely. An accurate and detailed bleeding history is of paramount importance

to establish the diagnosis of any bleeding disorder in general and of hemophilia in particular.

For correct evaluation of the history it is important to realize that hemophilia exists in various degrees of severity. Within the spectrum of hemophilia severity each patient usually maintains his own characteristic level of clotting factor functional deficiency. Furthermore, within a given family with hemophilia, the affected members usually have approximately the same degree of lack of function.

It is helpful to categorize the severity of the coagulation defect into three general classes:

1. In severe deficiency, the factor VIII or factor IX levels are characteristically less than 1% of normal (range of normal is 50% to 200%). Spontaneous hemorrhages occur, most frequently into muscles and large joints. There is marked susceptibility to hemorrhage following minor trauma.

2. In moderately severe deficiency, factor levels are 1% to 5% of normal. Hemorrhages do not usually occur spontaneously but are induced by moderate trauma.

3. In mild deficiency, factor levels are 5% to 35% of normal. When factor levels are above 5% hemorrhages occur infrequently and usually only follow severe hemostatic challenge such as surgical operations or severe trauma with open surface wounds of skin or mucous membranes. Thus, there may be no symptoms until adult life. Despite the negative history of bleeding,

once bleeding begins after major challenge, hemorrhage may be profuse and life-threatening, and only sensitive and accurately performed specialized laboratory tests assaying for the factor level will detect mild degrees of the deficiency.

Certain points are critical in taking a bleeding history.

1. All surgery and trauma should be evaluated in specific detail. It should be specifically questioned if the patient has ever had such common procedures as circumcision, tonsillectomy, extractions of permanent teeth, or injuries such as fractures or contusions.

If so, the timing and duration of the postoperative or post-traumatic bleeding is critical. Because the vasculature and the platelets are of primary importance in the initial hemostatic plug, excessive bleeding is usually apparent immediately in vessel or platelet defects, including disturbance of platelet function by drugs such as aspirin. In contrast, if a surgical procedure is followed by bleeding beginning *only* 24 hours after the procedure or is followed by excessive hemorrhage occurring after the procedure but persisting *beyond* 24 hours, the patient should be carefully evaluated for hemophilia or another plasma clotting disorder. If the postoperative bleeding is limited to the first 24 hours, it is usually not due to hemophilia, *unless* the patient required transfusion. One should always specifically ask if transfusion of any blood was neces-

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sary, because this information is frequently not volunteered.

2. The use of the term "bleeder" by the patient should be assessed by detailed descriptions of specific bleeding episodes. Easy bruisability is a common complaint, particularly among females, and often no defect can be demonstrated on in vitro testing. Excessive nosebleeds are usually not due to hemophilia, but are due to local problems, platelet function defects or thrombocytopenia.

3. In evaluating the neonatal period it should be remembered that even severe hemophiliacs often go through the major trauma of delivery without any bleeding complications.² The nature of this protection is not understood, and it is not due to transplacental transfer of maternal factor VIII, since the level may be less than 1% in cord blood. This protection, in some instances, will last for the first one to two weeks of life, and circumcision within the first 30 days of life caused no significant bleeding in 57% of severe hemophiliacs.²

4. The first symptom is usually easy bruisability at three to nine months.² Toward the end of the first year of life, concurrent with the infant becoming a toddler, the child becomes more susceptible to injuries, and spontaneous bleeding episodes (usually into subcutaneous

tissue or muscle) begin to occur in the severely affected patient. Hemarthroses usually occur only after age two to three.

5. Both hemophilia A and hemophilia B are transmitted by the sex-linked recessive mode of inheritance, as shown in Figure 1.

When a male carries the abnormal gene, he is affected by the disease. All of the daughters of an affected man are carriers, as they all inherit his abnormal X chromosome. None of the sons of a hemophiliac male are affected, as they all derive their single X chromosome from their mother.

When a female carries the abnormal gene, she is a heterozygous carrier, and is usually asymptomatic, although a few female carriers of hemophilia do have bleeding problems. Each child of a female carrier has a 50% chance of inheriting the mother's abnormal X chromosome, causing disease in the sons and the carrier state in the daughters.

Approximately one third of all patients with hemophilia A and one fifth of all patients with hemophilia B have no family history of hemophilia. Since more than 90% of these "de novo" patients are severely affected, most of them probably represent gene mutations in recent generations.³

Laboratory tests are necessary if

the personal history, the family history or the physical examination arouses suspicion that a bleeding disorder, including hemophilia, is present. Four basic tests are of critical importance in screening and should be supplemented as needed by further specialized tests.

1. *Platelets*: The number and morphology of the platelets should be evaluated on a peripheral smear and supplemented by a platelet count.

2. *Bleeding time*: The Ivy method measures the duration of bleeding from a small standardized cut on the forearm while a blood pressure cuff is maintained at 40 mm Hg. The bleeding time measures the adequacy of the primary hemostatic plug. Normal values with a 9 x 1 mm cut are usually 3 to 5 minutes, but range up to 10 minutes.^{4,5} The bleeding time will be increased in thrombocytopenia and will usually not need to be done if the platelet count is less than 50,000. The bleeding time is also prolonged in platelet dysfunction states and in von Willebrand's syndrome. It is useful to remember in a bleeding patient who may have ingested aspirin that aspirin should not prolong a standardized Ivy bleeding time in normal individuals beyond 21 minutes.⁴ Thus, if an accurately done bleeding time is longer than 21 minutes, it suggests another platelet-vascular defect in addition to that conferred by aspirin.

In hemophilia the initial bleeding time is normal. However, characteristically, the bleeding will restart and restop repeatedly because the initial platelet plug is not reinforced by normal fibrin formation. The initial bleeding time is markedly prolonged when a hemophiliac has ingested aspirin.⁵

Please refer to Figure 2, depicting the clotting cascade.

3. The *prothrombin time (PT)* is the time required for citrated or oxalated plasma to clot when recalcified in the presence of tissue thromboplastin. It measures the adequacy of the entire extrinsic coagulation system, including the final common pathway, and is nor-

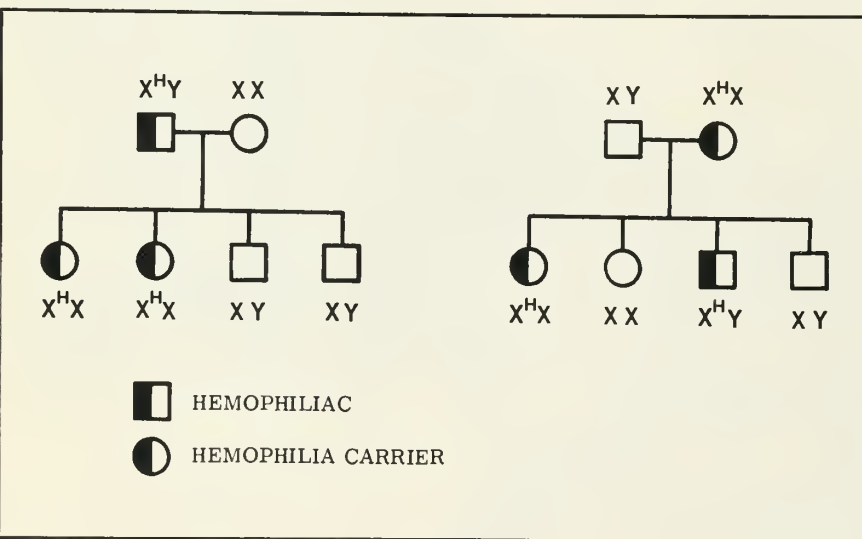


FIGURE 1

The genetic transmission of hemophilia.

mal in uncomplicated deficiencies of the intrinsic coagulation system, including hemophilia A and B.

4. The *partial thromboplastin time* (PTT) is the time required for citrated or oxalated plasma to clot when recalcified in the presence of crude cephalin, which is a "partial thromboplastin" substituting for the lipoprotein portion of the platelet membrane, which generates an activity referred to as platelet factor three activity.

In the *activated partial thromboplastin time*, the *in vitro* clotting reaction is accelerated by contact activation of factor XII or Hageman factor with kaolin or ellagic acid.

The PTT measures the entire intrinsic coagulation system, including the final common pathway. In the presence of a normal prothrombin time and a prolonged partial thromboplastin time, the final common pathway must be normal. Thus, an isolated prolonged PTT reflects an abnormality of the early stages of the intrinsic coagulation system, including factors VIII and IX. In this case, specific factor assays are necessary to pinpoint the defect. In practice, the coagulation laboratory would first do a factor VIII assay and then would do a factor IX assay because hemophilia A is much more common than hemophilia B.

Unfortunately, the PTT may be normal when factor assay activity is between 25% and 35% of normal. Thus, mild hemophiliacs may be missed even on these screening tests.

It would be highly desirable to be able to provide genetic counseling to potential female carriers such as mothers and sisters of sporadic cases of hemophilia or to daughters and sisters of known female carriers. For this, the ability to diagnose accurately the carrier state of hemophilia is crucial. Unfortunately, in only the minority of potential carriers are factor activity levels below the normal range, irrespective of the degree of severity of disease in the family.

A recent development which has

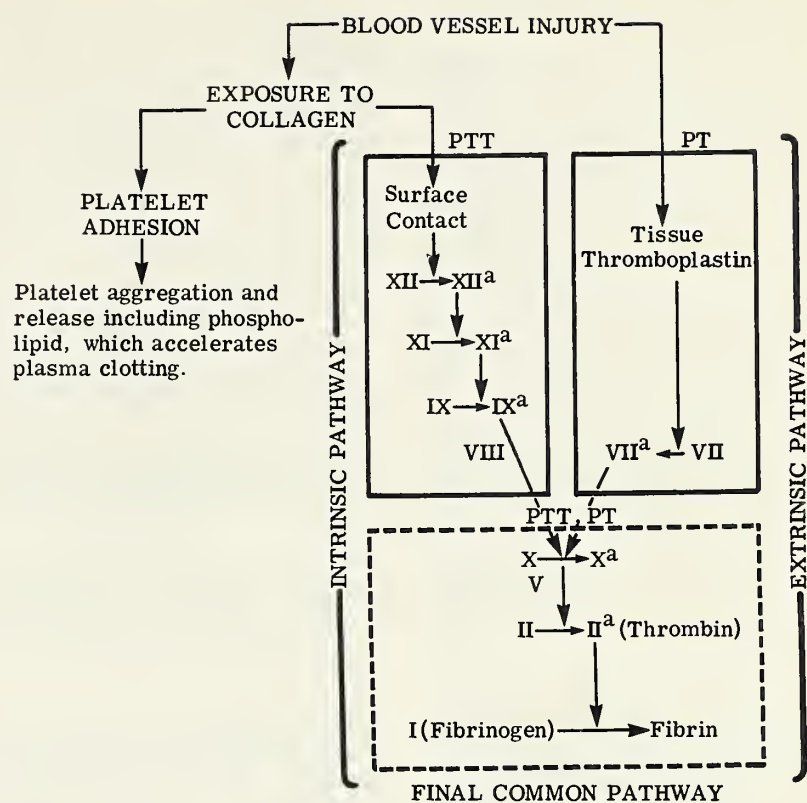


FIGURE 2

The blood coagulation pathway. The clotting factors are indicated by Roman numerals, with the activated form of the clotting factors depicted by ^a (e.g., IX^a). The function of the intrinsic pathway is measured by the partial thromboplastin time (PTT) and that of the extrinsic pathway by the prothrombin time (PT). The final common pathway is depicted by - - - -.

enabled increasing the accuracy of the diagnosis of the carrier state in hemophilia A is the purification of factor VIII from normal plasma and the production in rabbits of a specific antibody to human factor VIII.^{6,7} This enables a comparison of the level of factor VIII coagulant activity and the level of factor VIII antigen by the immunologic assay, as shown in Table 1.

In normal persons the levels of both coagulant activity and antigen are normal, and the coagulant/antigen ratio is 1.0.

In males with hemophilia A there is a low activity assay, but there are normal levels of factor VIII by antigen assay, giving a coagulant/antigen ratio of less than 0.2.

Females who are carriers of

Table 1
FACTOR VIII DEFICIENCY

	Normal	Hemophilia A	Carrier of Hemophilia A	von Willebrand's Syndrome
Coagulant activity	100% 1.0 units/ml	1% 0.01 units/ml	50% 0.5 units/ml	10% 0.1 units/ml
Antigen	1.0 units/ml	1.0 units/ml	1.0 units/ml	0.1 units/ml
Ratio VIII:C VIII:Ag	1.0	0.01	0.5	1.0

hemophilia A possess both the functionally normal and the functionally abnormal factor VIII in varying proportions. Thus, the activity assay is less than the antigen assay, giving a coagulant/antigen ratio in the 0.3 to 0.5 range. This has improved the ability to diagnose correctly at the 99% confidence level the carrier state of hemophilia A to 85% of all carriers in our laboratory.⁸ Most clotting laboratories in this country performing the specialized coagulant/antigen ratio test are also able to detect carriers 85% of the time. Unfortunately, fetal factor VIII and factor IX coagulant activity levels were both less than 1% in a series of 10 aborted normal fetuses of gestation lengths 11 to 22 weeks.⁹ Thus, all that can be offered for diagnosing hemophilia A in utero is amniocentesis.

In von Willebrand's syndrome there appears to be a true deficiency of factor VIII because the coagulant activity and the antigen are the same, giving a coagulant/antigen ratio of 1.0 (Table 1).⁷ These patients can be distinguished from the normal person with a coagulant/antigen ratio of 1.0 because of the low coagulant activity. Von Willebrand's syndrome is a congenital bleeding disorder, inherited in an autosomal dominant pattern, in which both platelet function and plasma clotting activity are abnormal, as manifested by a prolonged bleeding time (in vitro platelet function abnormalities demonstrable are decreased adhesion to glass

bead columns and absent aggregation with Ristocetin) and decreased factor VIII coagulant activity and antigen. Treatment with fresh frozen plasma or cryoprecipitate (but not with more highly purified factor VIII concentrates) restores normal function to the platelets and enables the patient to synthesize his or her own factor VIII.

The diagnosis of the carrier state of hemophilia B is much more difficult and at the present time one must rely on a decreased coagulant activity of factor IX for diagnosis of the carrier state.

Regarding therapy for the hemophiliacs, the daily life of a mild hemophiliac is usually nearly normal, as long as he receives adequate replacement therapy at the time of surgery, dental work or other trauma which would precipitate bleeding.

In hemophilia replacement therapy it is important to differentiate between two major types of hemorrhage: (1) enclosed soft tissue hemorrhage, which requires only moderate replacement therapy, and frequently can be treated by the patient at home or by the physician in the emergency room, and (2) surface wound bleeding, which requires replacement therapy which initially attains and then maintains high factor levels until the wound has healed, and requires hospitalization.

Table 2 delineates the clotting factor levels usually necessary to provide adequate hemostasis for

control of various types of hemorrhage.

With minor hemorrhage, an initial level of 15% to 20% is usually adequate. For minor to moderate joint hemorrhage, a single dose usually suffices. With full-blown hemarthrosis, muscle or soft-tissue hemorrhage, at least one repeat dose is usually necessary. Extensive muscle hemorrhage (e.g., thigh) or hemorrhage into a closed space (e.g., volar compartment of arm) which could lead to pressure damage of neurovascular bundles requires replacement therapy for at least several days.

With surgery, the level should initially be raised immediately preoperatively to a minimum of 50% to allow maintaining the clotting factor level above 25% for about 10 days and above 20% for another three to seven days to allow complete wound healing. In orthopedic or relatively avascular surgery, these levels must be maintained for an even longer period. With gastrointestinal bleeding, the levels must be maintained until the bleeding is controlled.

With suspicion of intracranial hemorrhage from any cause, the factor level should be raised to 100% of normal and must be maintained at 100% for at least one week after bleeding is controlled. Once the clotting factor deficiency has been corrected, the hemophiliac with a head injury should be evaluated with the indicated diagnostic procedures. Computerized axial tomography has virtually replaced carotid angiography as the preferred diagnostic procedure. After diagnosis and clotting factor replacement, the hemophiliac should then be managed as a patient without hemophilia, including neurosurgical intervention if indicated.

To calculate the dose of clotting factor necessary for replacement, it should be remembered that factor VIII is primarily confined to the vascular space, whereas about half of the factor IX infused will diffuse out of the vascular space. Thus, 1 unit/kg of factor VIII infused

Table 2
Percent Clotting Factor Activity Desired
15-20%

Type of Bleeding
Minor Hemorrhage
 Joint
 Skin
 Muscle
Major Hemorrhage
 Surgery
 Trauma
 Dentistry—
 local anesthesia

Initially 50% or greater
Maintain hemostatic levels by repeat infusions at biologic half-life until wound has completely healed

Head Injury

100%
Maintain these levels 7 days after bleeding controlled

will raise the level in vivo approximately 2%, but 1 unit/kg of factor IX infused will raise the level in vivo only about 1%. Factor VIII has a much shorter half-life of 8-12 hours in vivo, but factor IX's half-life is about 24 hours. Catabolism of the infused factor is increased post-surgery, by fever, by hyperthyroidism and by further hemorrhage. Thus, when it is important to maintain the therapeutic level, clotting factor replacement therapy needs to be monitored with factor assays to determine the in vivo recovery and biological half-life of the infused factor for the individual patient.

As depicted in Table 3, the level one wishes to achieve usually dictates the choice of clotting factor replacement.

Fresh frozen plasma provides 0.7 to 1.0 unit/ml of either factor VIII or factor IX. Above 10 to 15 ml/kg will lead to circulation overload resulting from the osmotic load of the infused protein leading to blood volume expansion. The patient should receive type-specific or compatible plasma.

Cryoprecipitate provides only factor VIII, not factor IX. One usually assumes 100 units/bag, but the actual yield of factor VIII can be quite variable between individual cryoprecipitate bags. Thus, the infused cryoprecipitate factor VIII needs to be assessed by a factor VIII activity assay of the patient's plasma when it is important to achieve a specific level of activity. The patient should receive cryoprecipitate derived from type-specific or compatible plasma.

The more purified, lyophilized factor VIII and factor IX concentrates have made it possible to achieve and maintain without volume overload the very high levels which are necessary for surgery or treatment of major trauma. The amount of factor VIII or factor IX contained in the lyophilized concentrates is quite variable between batches, but each lot is assayed so one should check the package insert for the amount of clotting factor one is infusing. It is also important to note that factor

Table 3 CONCENTRATION OF		
Product	Factor VIII 1 unit/ml	Factor IX 1 unit/ml
Fresh frozen plasma*		
Cryoprecipitate	About 100 units/bag (variable)	-0-
Factor VIII concentrates (VIII, XIII and fibrinogen): AHF — Abbott Factorate — Armour Hemofil — Hyland Humafac — Parke Davis Koate — Cutter	Assay results stated (200-1500 units/pkg)	-0-
Factor IX concentrates (Prothrombin complex— II, VII, IX, X): Konyne — Cutter Proplex — Hyland	Trace	Assay results stated (500 units/pkg)
* Volume limit for infusion: 10 to 15 ml/kg		

VIII concentrates provide only factor VIII. Factor IX concentrates are actually prothrombin complex concentrates providing factors II, VII, IX, and X in concentrated form; they also contain a trace of factor VIII. A rare, but important, side effect of the factor IX concentrates is that they appear to trigger thrombosis in special circumstances; thus the need for their use should be carefully assessed in patients who are at high risk for thrombosis, i.e., postoperative, bedridden patients, patients on fibrinolytic blocking agents or patients with liver disease.

A major problem of any blood product obtained from pooled sources, and especially from paid donor pools, is the high incidence of hepatitis. Among the hemophiliacs treated in the regional program of the Central Blood Bank of Pittsburgh, 12% had overt hepatitis with jaundice.¹⁰ In those hemophiliacs who had received fractions prepared from pooled plasma, the incidence rose to 22%. Concentrates of factor IX were associated with hepatitis about three times as often as were factor VIII concentrates from donor pools.

Dental prophylaxis is important for hemophiliacs, including regular

brushing, flossing, fluoride and regular visits to the dentist. The fibrinolytic blocking agent, epsilon amino caproic acid (AmicarTM), is useful adjunct therapy after initial clotting factor replacement following dental extractions or in controlling traumatic oral mucous membrane bleeding to prevent fibrinolysis of the clot once it has formed. AmicarTM is contraindicated in patients with hematuria because of the complication of urinary tract obstruction which has persisted for two weeks to four months.

It is critical for physicians to teach their hemophiliac patients to avoid platelet-function inhibiting drugs. The prime offender here is aspirin, which is unfortunately a component of many analgesic drugs, sold both by prescription and over the counter. Table 4 depicts a double-blind study of nine hemophiliacs where remarkable prolongation of bleeding time after aspirin was demonstrated.¹¹

It was also demonstrated that both acetaminophen (TylenolTM, DatrilTM) and propoxyphene (DarvonTM) were safe in therapeutic doses in the hemophiliac.

The greatest advance of recent years in the care of the hemophiliac is the use of home infusion therapy

Table 4

MEAN BLEEDING TIMES IN NINE HEMOPHILIACS BEFORE AND TWO HOURS AFTER INGESTION OF TEST AGENT¹¹

	Number of Tests	Mean Bleeding Time, Minutes
Before test agent	49	6.0
After test agent		
Placebo	17	6.5
Acetaminophen, 650 mg	9	6.0
Propoxyphene HCl, 65 mg	8	5.0
Aspirin, 1 g	15	24.5

Table 5

Annual Mean Cost Per Patient ¹²	Before Self-Therapy	With Self-Therapy	Cost Reduction	P Value
Factor VIII or IX Concentrate	\$3,359	\$2,862	15%	<0.01
Hospitalization Costs, Exclusive of Concentrate	\$1,845	\$ 208	89%	<0.001
Outpatient Professional Fees	\$ 575	\$ 138	76%	<0.001
Total Cost of Health Care	\$5,780	\$3,209	45%	<0.001

Table 6

PREVALENCE OF INHIBITORS IN HEMOPHILIA A AND B¹⁴

Year	HEMOPHILIA A			HEMOPHILIA B		
	Total Patients	Patients with Inhibitors	Prevalence Rate	Total Patients	Patients with Inhibitors	Prevalence Rate
1964	514	46	9.0%	116	9	7.8%
1970	1,486	95	6.5%	338	11	3.3%

for the severe hemophiliac. The patient and a responsible family member are taught the principles of infusion therapy and the technics of venepuncture and infusion of clotting factor concentrates. They are taught to recognize infusion as soon as they recognize symptoms such as mild limitation of motion and pain and not to wait for objective signs such as swelling, warmth or discoloration. They are also instructed to recognize more severe hemorrhages

such as retroperitoneal or intracranial bleeding, so that they will consult their physician when home therapy will not suffice. Because the patients infuse at the first symptom of hemorrhage, each individual bleeding episode can be controlled with much less replacement, but the frequency of infusion usually increases, because patients are more willing to treat more minor episodes, since they will not lose time from work or school by so doing.

Table 5 depicts data from patients treated at the Tufts-New England Medical Center.¹² There was a slight decrease of 15% in the cost of concentrates after self-therapy was instituted. Much more remarkable was the decrease in hospitalization costs resulting in a 45% reduction in the total cost of health care. The days lost from work or school were reduced from 26.3 to 6.8 days per year.¹²

A real concern for the severe hemophiliacs as they have increased exposure to replacement therapy is the development of a circulating anticoagulant. When infused into a hemophiliac with a functionally abnormal clotting factor (or a deficient clotting factor), the normal clotting factor contained in the concentrates acts as a foreign protein. The repeated antigen infusion of the functionally deficient clotting factor stimulates antibody production (usually IgG, rarely IgM) of an inhibitor specifically directed against the factor VIII or factor IX. The development of an inhibitor is a major problem for which several therapeutic approaches have been tried, but no therapy has been consistently satisfactory. The prothrombin complex concentrates which contain factors II, VII, IX, and X, also contain variable amounts of the activated forms of factor IX and factor X, and have been used in a few very small series to treat patients with factor VIII inhibitors of high titer with encouraging preliminary results.¹³ While this therapy is presently highly experimental, further study of this therapeutic approach is warranted because of the lack of effective alternatives for the treatment of patients with factor VIII inhibitors.

The International Hemophilia Centers care for a large number of severe hemophiliacs. Fortunately, their data (Table 6), demonstrate that there has been no increase in the number of patients demonstrating inhibitors in more recent years, as increasing numbers of the severest hemophiliacs have consumed ever larger quantities of the potentially antigenic concentrates.¹⁴

A special category for self-therapy is patients with extremely frequent hemorrhage or those in whom a single joint may need therapy over a long period of time to allow complete healing, and in this group prophylactic therapy has been tried. Dr. Robert Baehner of the James Whitcomb Riley Hospital for Children has let me cite their results of prophylactic therapy (Table 7) twice weekly raising the factor level to 100% in a small group of extremely severe hemophiliacs.¹⁵ The remarkable decrease in bleeding requiring hospitalization is most dramatic.

While long-term data are not yet available, it is thought that, by beginning self-therapy early, the chronic deformities and psychological problems of the severe hemophiliac can be prevented and he may be able to lead a reasonably normal adult life.

Discussion

Question: In view of the high rate of hepatitis following the infusion of the factor IX (prothrombin complex) concentrates, does either commercially available product have a lower risk for hepatitis?

Reply: In July 1972, U.S. Federal regulations required the testing of all donor blood for hepatitis B surface antigen by methods at least as effective as counterimmunoelectrophoresis. In a recent study, representative samples from lots of U.S. commercially produced plasma derivatives were tested for the presence of hepatitis B surface antigen by solid-phase radioimmunoassay, which is approximately 100 times as sensitive as counterimmunoelectrophoresis.¹⁶ In the 199 lots of factor IX concentrates from 1971 to 1975 from the two U.S. manufacturers, none of the lots were positive for hepatitis B surface antigen by counterimmunoelectrophoresis, but 40% were positive by radioimmunoassay. All of the positive lots were produced by a single manufacturer. As of early 1975, this manufacturer voluntarily adopted a policy of testing all lots by radioimmunoassay and distributing only

Table 7						
PROPHYLACTIC REPLACEMENT THERAPY						
(James Whitcomb Riley Hospital for Children) ¹⁵						
			BEFORE RX		AFTER RX	
	Age	Hospital Days	Risk Period	Hospital Days	Risk Period	
DF	9 ½	50	720	0		1440
SF	11 ¾	50	1800	9		1800
CB	12	48	2340	0		630
D Lat	9	100	2880	0		360
A Lat	11 ½	200	4320	0		360
RM	15 ½	275	4680	11		720
AVERAGE		121	2790	3		885
Hospital Days		1		1		
Risk Period		23.2		295		

those lots which were nonreactive, so that at present all factor IX (prothrombin complex) concentrates appear to be negative for hepatitis B surface antigen, as determined by solid-phase radioimmunoassay.

Dr. Jessica Lewis of the Central Blood Bank of Pittsburgh has kindly allowed me to quote her data currently in press. Since March 1973, all donors and blood products at the Central Blood Bank of Pittsburgh have been tested for hepatitis B surface antigen by radioimmunoassay and positive donors or products rejected. Of hemophiliacs treated solely with cryoprecipitate, only 16% developed elevated liver function tests (SGOT or SGPT). Of those hemophiliacs treated with VIII or IX fractions from pooled sources, 84% developed elevated liver enzyme tests.¹⁷ Of hemophiliacs negative for hepatitis B surface antigen by solid-phase radioimmunoassay, all the hemophiliacs treated with pooled fractions of either factor VIII or IX concentrates, and 50% of the hemophiliacs treated solely with cryoprecipitate (factor VIII) developed antibodies to hepatitis B surface antigen.¹⁸ This suggests that hepatitis B surface antigen has not been excluded from the donor pools, even though they were negative by solid-phase radioimmunoassay.

Dr. Walter J. Daly: In patients with a negative bleeding history who are about to undergo angiography or surgery, what is the yield of doing screening tests? Are there any studies of cost-effectiveness?

Reply: I am unaware of a cost-effectiveness study of the value of the bleeding screening tests. Most adults have had extractions of permanent teeth, and this procedure provides an excellent hemostatic challenge about which a physician can make specific, detailed inquiry as to the amount and timing of bleeding. One should also take a careful drug history with particular regard to aspirin, which is contained in many over-the-counter preparations which patients would not necessarily identify as "medicine" unless specifically questioned.

If one does the screening studies, it is important to assess platelet function with a carefully performed bleeding time. From the standpoint of the coagulationist, while the vast majority of preoperative patients will have normal screening tests, it is better to identify the abnormal patient preoperatively and provide appropriate replacement therapy than to try to halt bleeding postoperatively, because bleeding is more difficult to control once begun. We have recently evaluated a patient who had an abnormal acti-

vated partial thromboplastin time preoperatively and shown that he had mild hemophilia. This 40-year-old gentleman had no history of bleeding after moderate trauma and had served three years in the U.S. Air Force without incident. However, he had had no prior major hemostatic challenge. Therefore, while the screening tests may be most valuable from the viewpoint of the individual patient, it is difficult to evaluate their cost-effectiveness for the population as a whole.

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Osler's Diabetic Diet

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Tampa, Florida

Summary

A comparison is made between the diabetic diet recommended by Sir William Osler in his 1911 textbook and a present day 2,000 calorie ADA exchange diet. The Osler diet appears to be quite palatable and was very effective in reducing glycosuria. Even though insulin and oral hypoglycemic agents are now available, clinicians should remember that carbohydrate restriction alone is a valuable part of the management of diabetes.

The Osler Diet

The majority of American physicians will utilize the exchange diet system as developed by the American Dietetic Association and the American Diabetes Association in the management of most adult diabetic patients.

For some years, however, a relatively unrestricted diet has been advocated by some clinicians.¹ Their underlying clinical impression seems to be that an even less strict dietary program may be appropriate for the majority of adult onset diabetics.^{2,3,4,5}

It has also been known that despite such a dietary outline the average practitioner is rather poorly schooled in dietary knowledge while in medical school. This relative ignorance is reflected in his clinical management of patients regarding dietary instructions.

With these thoughts in mind, it seemed appropriate to review the dietary therapy recommended by physicians prior to the availability of insulin. At that time in the practice of medicine dietary therapy was the only therapy that the clinician

had to offer. In such an era physicians would have been more knowledgeable about dietary management. Accordingly, it might be wise for all clinicians to review Osler's *Practice of Medicine* to see the form of dietary therapy, which was compiled from a list recommended by von Noorden, this outstanding clinician recommended for his own patients and taught to his medical students and house staff. The 1911 edition of this textbook offers the following daily meal plan for a diabetic.⁶

Osler's Diabetic Diet

Breakfast 7:30 a.m.

6 oz. tea or coffee
4 oz. beef steak, mutton chops
without bone or boiled ham
1 or 2 eggs

Lunch 12:30 p.m.

6 oz. cold roast beef
1½ oz. celery, fresh cucumbers
or tomatoes with vinegar,
olive oil, pepper and salt to
taste
20 cc whisky with 400 cc water
1½ oz. coffee without milk or
sugar

Dinner

6 oz. clear bouillon
7½ oz. roast beef
10 grams butter
1½ oz. green salad
10 grams vinegar
20 grams olive oil
3 sardines
20 cc whisky with 400 cc water

Supper 9:00 p.m.

2 eggs raw or cooked
12½ oz. water

The diet listed above contains approximately 200 grams of protein and 135 grams of fat. This diet, therefore, consists roughly of 2,035

calories, including the calories from the whisky.

According to Osler's instructions, the diabetic patients should be hospitalized and placed on an ordinary diet for three or four days, during which time carbohydrate excretion in the urine was measured. After this control period the carbohydrate in the patient's diet was reduced over a period of two days until he was placed on the above diet, which is carbohydrate free.

For patients who showed an absence of glycosuria on the above diet, it was Osler's practice to liberalize the diet gradually by adding carbohydrates. The carbohydrate might be increased to 20, 50 or 100 grams a day, depending on the patient's condition. Another diet, the oatmeal diet, as introduced by von Noorden, is mentioned by Osler in the text but this seems to be reserved for more severe cases.

A comparable 2,000 calorie ADA exchange diet of today, providing roughly 40% of the total calories as carbohydrate, would consist of 205 grams of carbohydrate, 100 grams of protein and 85 grams of fat, which presents a sample meal plan as follows.⁷

Breakfast

1 orange
¾ cup dry cereal
1½ slices toast
2 eggs
1 slice crisp bacon
2 t. margarine
1 cup milk, 2%

Lunch

2 1½ oz. slices cold cuts
1 oz. cheese
3 slices bread
As desired tomato salad
1 small apple
1 t. margarine
1 t. mayonnaise

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Dinner

3 oz. chicken, baked
½ cup potatoes, mashed
2 slices bread
As desired salad of lettuce,
celery, cucumbers, radishes,
etc.
½ cup peas
½ cup fruit cocktail
1 T. french dressing
1 t. margarine

Bedtime Feeding

1 cup milk, 2%
2 squares graham crackers
or
2 slices bread
1 oz. roast beef, lean

It is interesting to note in Osler's diet the inclusion of whisky in two meals during the day. The ADA exchange sheets prohibit all alcoholic beverages unless permitted by the patient's physician. Some support for a moderate intake of alcoholic beverages by diabetic patients has been reported,⁸ but this viewpoint is not shared universally.

Of particular interest is a graph cited by Osler which shows a urin-

ary excretion of glucose ranging from roughly 300 to 600 grams per day while a diabetic patient was on the standard hospital diet and the marked reduction within three days after institution of the diet he recommends. Urinary glucose excretion fell to under 50 grams per day, where it remained during the patient's hospital stay. It must be stated, however, that no form of dietary therapy was, of course, of any great prolonged benefit to patients with severe, juvenile-onset type of diabetes mellitus.

Few physicians from the "pre-insulin era" are still actively treating diabetic patients now. This may add to the lack of appreciation of a strictly regulated carbohydrate intake in diabetics' diets. This fact is coupled with the meager instruction that most medical students receive in dietary therapy. These factors probably contribute to the less than optimal dietary instruction that is given to many diabetic patients.

In view of these points, plus the fact that Osler's diet appears palatable, we should not forget that carbohydrate restriction is an im-

portant aspect of diabetic management.

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From THE JOURNAL 50 Years Ago

Within recent months smallpox has gained considerable headway in the state of Indiana. This unfavorable condition of affairs can be credited to the work and influence of the Christian Scientists, the members of the League for Medical Freedom, the members of the Anti-Vaccination Society, and a lot of other fanatics who have fought medical progress at every turn and managed to have their vicious influence felt sufficiently to give such communicable diseases as smallpox a chance to thrive. Most of these obstructionists claim that smallpox is a disease that is bred in filth and that proper sanitation and plenty of sunlight will prevent the spread as well as cure the disease. Nothing could be further from the truth, as smallpox may develop in an individual who lives under the most sanitary conditions and who follows all of the accepted rules of health outside of adopting vaccination as a preventive measure. The public should know that smallpox never develops in persons who have been vaccinated successfully within recent years, and that there is an overwhelming mass of evidence to prove the efficacy of vaccination in stamping out the disease. Sometimes we think it would be a blessing if we did away with prevention of every kind for the purpose of teaching the people what can occur when they pay no attention to established rules of procedure in the protection of health and life, but the trouble with that plan is that many innocent would suffer along with the guilty. . . . —Editorial "Smallpox in Indiana," *JISMA*, July 1927.

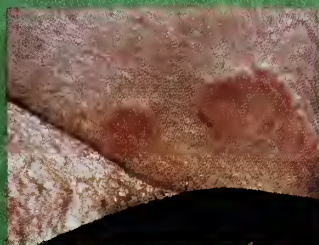
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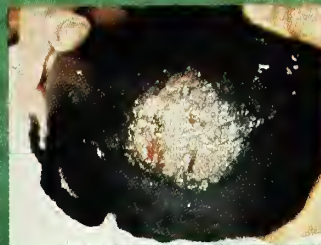
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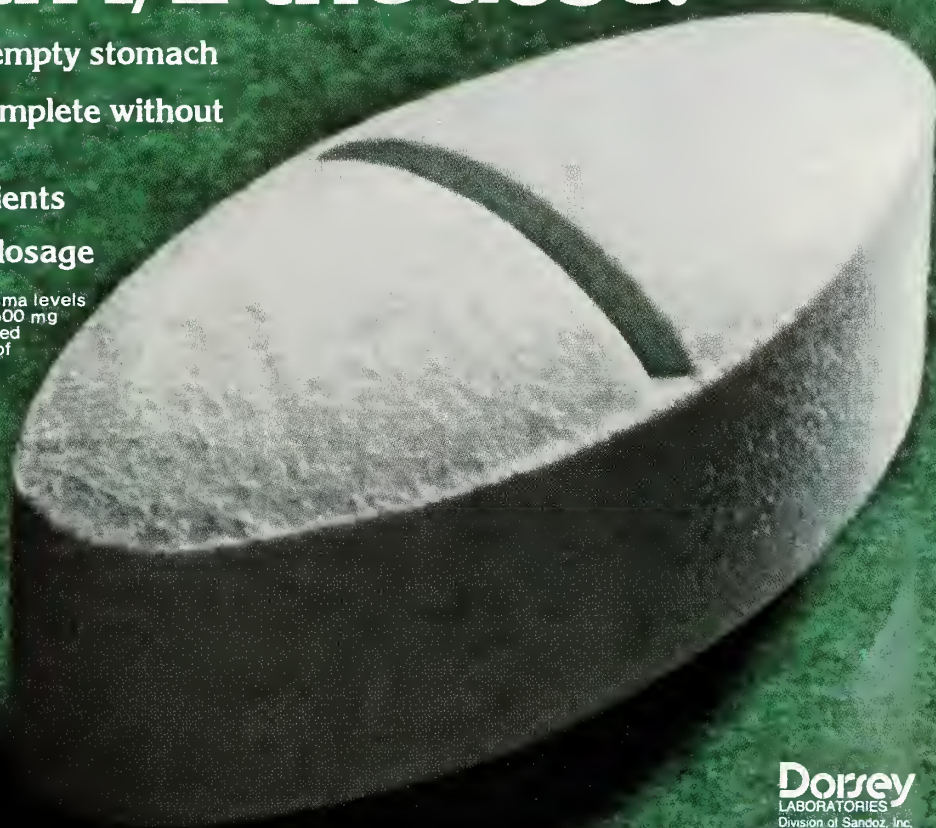
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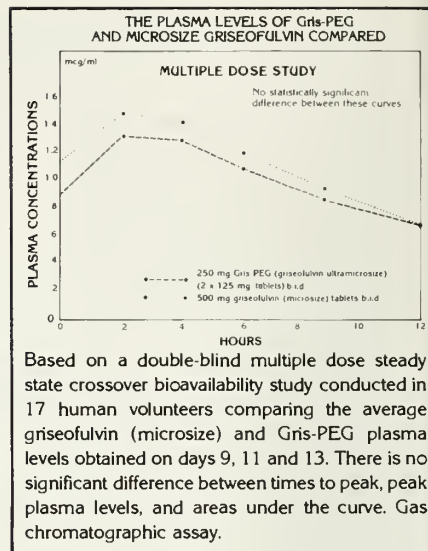
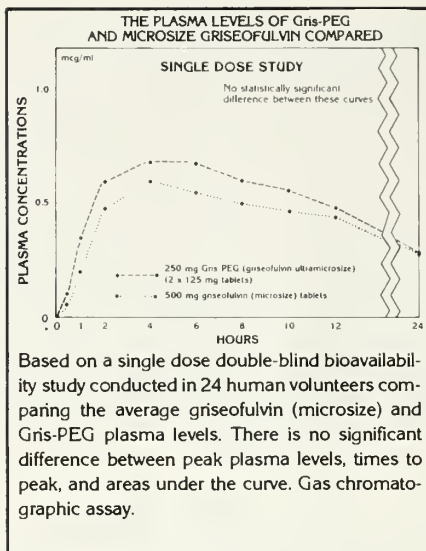
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Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG Tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsize griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections:

- Tinea corporis* (ringworm of the body)
- Tinea pedis* (athlete's foot)
- Tinea cruris* (ringworm of the thigh)
- Tinea barbae* (barber's itch)
- Tinea capitis* (ringworm of the scalp)
- Tinea unguium* (onychomycosis, ringworm of the nails)

when caused by one or more of the following genera of fungi:

- Trichophyton rubrum*
- Trichophyton tonsurans*
- Trichophyton mentagrophytes*
- Trichophyton interdigitalis*
- Trichophyton verrucosum*
- Trichophyton megnini*
- Trichophyton gallinae*
- Trichophyton crateriform*
- Trichophyton sulphureum*
- Trichophyton schoenleinii*
- Microsporum audouinii*

Microsporum canis
Microsporum gypsum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *NOT* effective in the following:

- Bacterial infections
- Candidiasis (Moniliasis)
- Histoplasmosis
- Actinomycosis
- Sporotrichosis
- Chromoblastomycosis
- Coccidioidomycosis
- North American Blastomycosis
- Cryptococcosis (Torulosis)
- Tinea versicolor*
- Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage. Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology. Chronic feeding of griseofulvin, at levels ranging from 0.5 to 2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy. The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies. It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral ad-

ministration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress. Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists, however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSEAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potas-

sium hydroxide or by a culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks, *tinea corporis*, 2 to 4 weeks, *tinea pedis*, 4 to 8 weeks, *tinea unguium*—depending on rate of growth—fingernails, at least 4 months, toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsize) USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children. Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis the following dosage schedule for children is suggested. Children weighing over 25 kilograms (approximately 50 pounds) 125 mg to 250 mg daily, children weighing 15-25 kilograms (approximately 30 to 50 pounds) 62.5 mg to 125 mg daily, children 2 years of age and younger, dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin microsize tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin, biologically equivalent to 250 mg of microsize griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsize griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

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Indications for Blood Transfusions and Proper Component Selection

GREGORY N. LARKIN, M.D.
Greencastle

Introduction

ALTHOUGH in vivo application of blood transfusion was recorded as early as the seventeenth century, practical medical use has occurred only within the last few decades.¹ With scientific advances in the fields of immunology, serology and cytology, blood transfusion can better be defined in regard to indications, risks and benefits. By today's guidelines, one study has reported that 27% of multiple and 60% of single unit transfusions were not indicated.¹

Many solutions are available for intravenous duplication of circulating plasma and various blood components.⁵ However, the scope of this article will focus on replacement of the oxygen carrying component of the blood, the red blood cell. Also, this short essay will not attempt to cover all the indications for blood transfusion, but instead will provide a practical approach to and understanding of the more common situations in which transfusions are indicated.

Indications

Generally, four main indications are recognized. These are (1) acute or subacute blood loss, (2) severe anemia or hemolytic crisis, (3) supportive care for genetically deficient components of the clotting system or the red cell structure, and (4) exchange transfusions necessary in hemolytic disease and Sickle Cell anemia.³

Most commonly, the first two indications are dealt with daily by the family practitioner, with the treatment of the latter two indications generally being initiated by a hematologist. The infrequent and

rare indications will be excluded from this discussion.

ANEMIA: Best defined as a reduction of the concentration of hemoglobin in the presence of near normal blood volume.³ The onset may be acute or chronic. Anemia does not necessarily indicate blood transfusion.⁶

Acute anemia secondary to blood loss can be either due to a surgical procedure or an accident. Unless the blood loss is massive or the patient is clinically symptomatic, transfusions should be withheld. If the blood loss can be measured (i.e., surgical sponge weighing and/or CVP monitoring) a loss that exceeds 10% to 20% of the circulating volume will usually require transfusion.²

Significant surgical blood loss that can be predicted should be preceded by typing and cross-matching to avoid a cardiovascular crisis.⁶

In chronic or subacute anemia the causes will vary. Proper diagnosis of the etiology is important prior to institution of therapy.³ A practical understanding of hematology will demand a thorough history of a patient's environment, including diet, type of employment, chemical exposure, family health history and drug usage of both the over-the-counter and prescription remedies.¹ Appropriate laboratory support will vary with suspected etiology but the basic data should be a complete CBC including MCV (mean corpuscular volume) and a reticular cell count. Often knowledge of the MCV of a chronically anemic patient will be of great help, since the classification of the cells as micro-, normo-, or

macrocytic will quickly help decide whether the more expensive tests such as serum iron, iron binding capacity, total iron, B12, folate acid, etc. will be needed.⁶ A reticular cell count will help determine the blood forming systems' ability to physiologically respond to the anemia.

Blood transfusions are seldom needed in the chronically anemic patient. However, the indications in this type of patient include (1) chronic blood loss secondary to gastrointestinal bleeding in which the patient becomes symptomatic, (2) chronic anemia that is NOT REMITTENT to therapy (with proper therapy varying with the proper diagnosis) and/or when the patient is symptomatic, and finally (3) the chronically anemic patient who is scheduled for emergency surgery.^{1,2} Any transfusion of such patients should be approached with caution. These patients have often developed compensatory mechanisms which must be dealt with after increase of the circulating blood volume or red cell mass.³

Of course, regardless of the etiology of the anemia and regardless of the mode of onset, if the patient is acutely symptomatic a blood transfusion is indicated.

Invalid Indications

It is not uncommon for a medical audit committee to review transfusion usage in a hospital and discover there are several common invalid indications for which transfusions were given. Primarily, these include hypovolemia without massive hemorrhage, dehydration or renal output failure, elective surgery patients with chronic anemia who have not had an adequate diagnostic workup or trial on oral treatment,

or a transfusion given to a chronically ill patient to boost the patient's immunological defenses by transfusing antibodies and other unknowns.³

Since any transfusion is not without risk, decisions must be made in regard to the patient's actual needs.⁶ If volume is solely needed, volume expanders are the modality of choice. If the patient has a nutritional anemia, time and oral replacement of the deficiency is the correct approach. Seldom, if ever, should a transfusion be used in an attempt to strengthen a weakened patient's immunological status. Immunological preparations are available on the research level but proper indications and availability are rare.⁶

Component Selection

Once a patient is found to have a valid indication for a blood transfusion it is necessary to decide which type of blood component will be the most beneficial with the least amount of risk. In an average community hospital the two most commonly available and used components are whole blood and packed red blood cells. In the discussion to follow it will be assumed that the whole blood is fresh (less than 24 hours old) and that the red cells were packed immediately prior to transfusion and are completely free of plasma. PRBCs (packed red blood cells) that are not so prepared will not have all the advantages cited in this article.⁶

Whole Blood Transfusions

It is believed that the only indication for whole blood transfusion is acute massive hemorrhage which results in hypovolemia and serious loss of red cells.¹ Such patients usually present either in the emergency room or in the surgical suite.

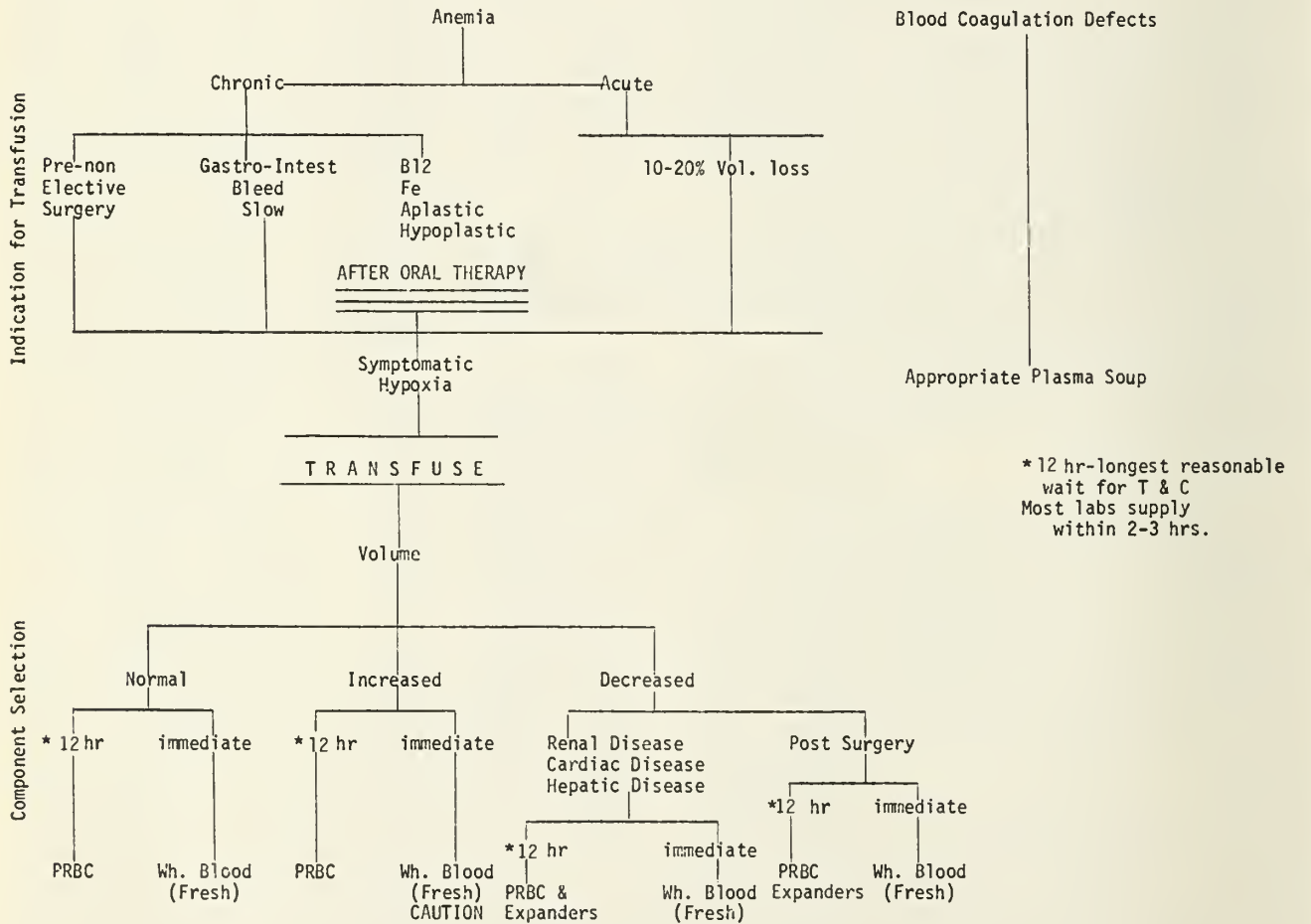
In controlled conditions such as surgery packed red blood cells may be used with a volume expanding solution if the volume loss is less than 1,500 cc.² By utilizing this combination some of the disadvantages of whole blood will be avoided.

ADVANTAGES OF WHOLE BLOOD:

A) Generally less expensive than other prepared components.

INDICATIONS FOR BLOOD TRANSFUSIONS AND PROPER COMPONENT SELECTION

BLOOD TRANSFUSIONS ARE NOT WITHOUT PATIENT RISK AND SHOULD BE USED ONLY IN SEVERELY SYMPTOMATIC PATIENTS WHO DISPLAY ANEMIAS OF ACUTE, MASSIVE ONSET OR CHRONIC ONSET WHICH ARE UNREMITTENT TO ORAL THERAPY, AND IN CHRONIC ANEMIA PATIENTS IN PREPARATION FOR NON-ELECTIVE SURGERY.



B) Usually easier to obtain and more rapidly available.

C) Contains platelets and Factors VIII and V. Many authorities, however, question the actual benefits realized by these factors.⁶

DISADVANTAGES OF WHOLE BLOOD:

A) Suspected increased incidence of viral hepatitis over PRBCs.⁴

B) Increased incidence of transfusion reaction over PRBCs. A large percentage of reactions are believed to be due to the presence of platelets, white blood cell antigens and plasma proteins which are inherent in whole blood.⁴

C) Increased incidence of volume overload as compared to PRBCs. In whole blood transfusions a larger quantity of fluid will be delivered to the patient; although many individuals may tolerate this, patients with either cardiac or renal complications may have a difficult time with the extra volume.⁶

Packed Red Blood Cells

Packed red blood cells whose preparation follows the guidelines noted above have the uses and indications below:

A) Chronic anemia that is not remittent to an adequate trial of therapy.⁶

B) Anemic patients who are symptomatic but, due to other systemic complications, cannot tolerate additional volume (i.e., cardiac failure or renal failure).

C) Acute anemia with substantial volume loss, if the estimated blood loss is less than 1,500 cc and volume expanders are also administered.²

D) Most aplastic or hypoplastic anemias of various etiologies.

E) Certain chemotherapy patients who have suffered myelosuppressive effects.⁶

ADVANTAGES—PRBCs

A) Suspected decreased incidence of viral hepatitis.⁴

B) Decreased incidence of transfusion reactions due to absence of platelets, WBC antigens and plasma proteins. Therefore, a decreased incidence of antigenic renal shutdown.⁶

C) Decreased incidence of cardiac failure due to volume overload.

D) Less potassium and ammonia than is found in stored whole blood; therefore, less dangerous for renal, cardiac and hepatic diseased patients.¹

DISADVANTAGES OF PRBCs:

A) Generally more expensive than whole blood.

B) Generally requiring more time and preparation. Most laboratories should be able to render a suitable unit of PRBCs within three to six hours after the request.

C) Packed red blood cells, by definition, will not contain active platelets or Factors VIII or V. As noted earlier, the actual value of these missing items is under definite question.⁶

Conclusion

Review of the recent literature concerning the indications and contraindications for blood transfusion emphasizes pertinent points:

A) Never give a transfusion unless true indications are present. Blood transfusions are never without patient risk and should be used only in severely symptomatic patients who display anemia of acute, massive onset or of chronic onset which is unremittent to therapy or in the chronically anemic patients in preparation for non-elective surgery.

B) Blood transfusions are never indicated for pure volume replacement or for the attainment of an arbitrary hemoglobin level.⁵

C) Component selection should include consideration of actual needs

of the patient and potential risks involved.

In general, packed red blood cells are the component of choice in most transfusions because of:

A) less risk of side effects.

B) usually better adaptation to the physiological needs of the patient (increasing the oxygen carrying capacity of the circulation).

C) wider application to patients of various systemic diseases, including renal, heart and hepatic compromise.

Whole blood has little indication except for the situation of acute massive blood loss in which the red blood cell loss and the volume loss is significant. Banked whole blood (longer than 24 hours) is seldom indicated and carries the highest risk of potential side effects.⁶

When guidelines of modern hematology are utilized, hospitals should record higher usage of PRBCs and infrequent use of whole blood. Also, adequate chart documentation should show pre-transfusion diagnostic evaluation of chronically anemic patients. Finally, the number of transfusions for the chronically anemic patient undergoing elective surgery should decrease, as would the total number of blood transfusion reactions or complications secondary to the transfused blood or to the recipient's systemic illnesses.

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ESTATES

Treatment of Chronic Pain in a Community Hospital Rehabilitation Center

KARL L. MANDERS, M.D.
Indianapolis

THE Community Hospital Rehabilitation Center for Pain is now completing its third year of operation. We have recently completed a statistical study of our results with the treatment of several hundred patients. This paper will discuss and summarize these achievements.

The program is a holistic one utilizing the newest physiological, psychological and surgical techniques as well as resurrecting older approaches which, for one reason or another, have not been pursued for a period of time. A unique aspect of the program is the utilization of multiple modalities of treatment, all of which are equally stressed to the patient. The program is tailored to each patient's particular needs. We are concerned with those who have chronic benign pain and who have already exhausted the routine medical and surgical treatment. The final goals of the program are freedom from or reduction of pain, elimination of dependence on drugs and the return to both social and vocational activities.

All patients are initially selected through a careful screening process, and in all cases the diagnosis will have been completely established and no occult difficulties should exist. A complete social service workup and Minnesota Multiphasic Personality Index are completed on a preadmission basis.

The program is an intensive one. Physical and recreational therapy utilizing ambulation, stationary bicycle riding, swimnastics, flexion exercises and therapeutic massage

are encouraged. Bedrest is discouraged and the program is planned to keep the patient active throughout the entire day.

A medication program utilizing behavior modification and operant therapy results in narcotic and tranquilizing medication being gradually withdrawn, and all patients are removed from these medications by the time they complete the program.

A trained social service worker with a strong background in psychology is an integral part of the program, and insights are developed into the relationship of the patient to his or her own family, as well as to vocational and social adjustments in their life. Couple counseling and communication training is emphasized, and we insist that the family is brought into the program.

Vocational rehabilitation, counseling and active commitment to help the individual return to some type of productive job is extremely valuable.

Transcutaneous nerve stimulation is attempted on all patients and about two thirds of them derive some benefit. Facet rhizotomy for back and leg pain, especially in those who have not had multiple back surgical procedures, is a valuable adjunct in therapy. In addition, for those who have had multiple back surgeries performed, epidural and local blocks performed by the anesthesia department are helpful. Seventy percent of the patients undergoing such blocks obtained partial to complete relief. As the program has grown in diversity we have utilized surgical procedures to a lesser degree. However, percutaneous implantation of neuro-

pacemakers in very carefully selected patients has been done in 18 individuals. Our success rate of 80% of surgical implants compares to the overall national average of 20%. It is our belief that a pain program should be pursued before any implant is carried out.

Biofeedback training, primarily electromyographic and thermal in nature, is used extensively. Group workshops for discussion of pain and pain behavior and individual and group discussions with the pain psychologist are continued throughout the program.

The pain program at the Community Hospital Rehabilitation Center extends usually from four to six weeks for each participant, and a coordinated program for the return of the patient to family and job is completed prior to discharge.

We have an age range in the program from the early 20s into the 70s; however, we find that the patients who are older, especially physiologically older, do not do as well as the younger ones.

The results of this type of program have demonstrated that all our patients have had a marked reduction or complete elimination of all prescription pain medication, and they all have had marked increase in mobility and exercise tolerance. Body mechanics are markedly improved. No patient using crutches or braces at the time of admission has utilized them at the completion of the program.

Eighty-five percent of the patients treated at the Center have ceased further medical care for their original pain, and 25% have returned to work. In regard to the latter figure, one must realize that

From the Rehabilitation Center for Pain, Community Hospital, Indianapolis.

many of our patients are housewives or already retired, and that none were working at the time that they were admitted to the Center.

Return to social activities is gained by most of our graduates.

The clinical results, as we are entering into our fourth year of operation, have justified the initial optimism at the time of founding. We intend to continue our contemporary approach for the comprehensive treatment of pain, and we

certainly are encouraged that the multiple modality treatment can be a reasonable final solution for this disability. ◀

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Hypertension Series Commencing

THE JOURNAL is pleased to announce a series of clinical articles on the important subject of hypertension.

This issue contains the first of a long succession of short discussions which, when completed, will have covered the multitudinous aspects of epidemiology, diagnosis and therapy.

Peripheral vascular hypertension is endemic in the United States. It is characterized by being non-symptomatic throughout most of its course, and it usually creates subjective signs after the development of cardiovascular complications.

The discovery of hypertension is simple. Determination of the basic cause is a bit more complex. However, it will require all the ingenuity and persuasiveness that can be mustered by the medical profession to induce the millions of non-symptomatic hypertensives to follow even the simplest therapeutic program—a program which, if it is to be effective, must be adhered to during the remainder of the patient's life.

Indiana University School of Medicine is the site of one of the four Specialized Centers of Research in Hypertension (SCOR), in the United States. The Center is funded by the National Institutes of Health and is devoted to a multi-

disciplinary attack.

Indiana University is now in its seventh year of research. The Center comprises 22 physicians representing the clinical disciplines of Internal Medicine, Endocrinology, Nephrology, Cardiology, Physiology, Obstetrics and Gynecology, Medical Genetics, Radiology, Nuclear Medicine and Urology, as well as 7 basic scientists representing the Departments of Pharmacology, Physiology and Genetics.

Activities of the Center are directed toward several aspects of both clinical and basic science investigation in hypertension.

In addition, both Indiana University Hospital and the Veterans Administration Hospital in Indianapolis have hypertension clinics for evaluation and treatment. These clinics are a referral resource for physicians in Indiana and neighboring states.

These clinical services have developed new technics for diagnostic studies and have available a variety of experimental anti-hypertensive drugs for use in patients who are refractory to conventional therapy.

Readers are invited to direct clinical questions and to nominate subjects for future discussion by writing to Dr. Myron H. Weinberger, who is director of the Specialized Center of Research in Hypertension, 1100 W. Michigan St., Indianapolis 46202.

Guest Editorial

Maximum Sense Needed On the Minimum Wage

CAN you imagine your congressional representative voting for a bill to make it harder for black teenagers to get jobs? No?

Sounds most unlikely, doesn't it? Well, the trick is, you call the bill a bill to raise the minimum wage rate. Then everybody can vote for it with a clear conscience, because everybody likes to get a raise.

The problem is that while Congress can require an employer to pay his employees more money, it cannot create the money to pay them with. And employers have money problems, just like employees. So when an employer is forced to pay more money than a job is worth, he simply eliminates the job. He has to. Otherwise, he'd go broke himself.

Obviously, the first jobs to go are the low-paying jobs. And the low-paying jobs are those that require the least skill, the jobs that are usually "first" jobs for teenagers and school dropouts.

Low-paying jobs are not ideal, but they are better than no job at all. Also, they may enable the jobholder to upgrade his skills while he works, so he can advance to higher-paying work.

In the past, whenever the minimum wage has gone up, so has teenage unemployment. There is

every reason to expect that history will repeat itself this time.

By increasing unemployment, higher minimum wage rates may also have an indirect effect on inflation. What happens is that the Federal Reserve System, worried by the unemployment rate, increases the money supply faster than economic conditions warrant, to stimulate the economy. And the Fed has in fact been doing just that.

But there is a time lag of several months between an expansion of the money supply and the desired stimulative effect. Therefore, if the economic recovery continues to gain momentum, the Fed's boost may be felt at a time when the economy is again at full capacity. And that means more inflation.—**Arch N. Booth, former executive vice president, Chamber of Commerce of the United States.**

Editorial Notes . . .

William Lilley III, acting director of the President's Council on Wage and Price Stability, advises strongly against any efforts by government to control inflation of health care costs. Lilley says that if federal takeover of the health care system is to be avoided, the private sector—industry and labor—must devise means of control. Lilley is also quoted: "Federal takeover of the public system would be a prescription for disaster."

The Pharmaceutical Manufacturers Association has adopted a new set of guidelines for monitoring clinical drug testing. Some of the guidelines are more stringent and more specific than the FDA requires. The main thrust of the new standards is to more clearly define the role of drug firms in their role as sponsors, and to clarify company and clinician responsibilities.

Children do not get as much protection in autos as they should have. A survey, reported by the AMA, reported that of more than 5,000 automobiles in which children were passengers 93% under the age of 10 were not restrained. Also, 81% of passengers 10 or older and 78% of drivers had not fastened their seat belts. Children should be provided with special restraining devices of adequate design. Some devices on the market are not adequate.

"The increased use of the liability system to seek reparations despite a lack of negligence or malpractice has an adverse effect on all elements of the American health care system and can impede development of programs in the public's interest. There is a growing tendency to seek recovery through the liability system for injury which is incidental to or an unexpected result of medical treatment and does not involve negligence or malpractice." Spoken by Robert N. Gilmore, Jr., senior vice president-legal affairs, for the American Insurance Association before the recent National Drug Trade Conference.

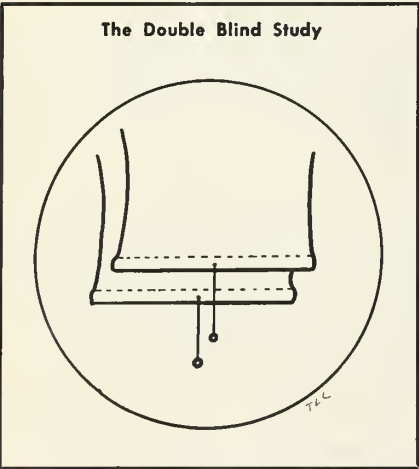
The American Insurance Association recognizes that some progress has been made in revising the laws that govern medical malpractice. Robert N. Gilmore, Jr., the Association's legal spokesman, stresses that one of several additional improvements would be a scheduled benefits type of law, administered by a special commission, and utilizing awards similar to those of workers' compensation. Payments for com-

pensable injuries would be dependent on a finding of fault, with no recourse to trial courts. All medical expenses would be reimbursed. Other payments would follow a schedule similar to workers' compensation.

The death rate for legal abortions, according to the Center for Disease Control, as based on more than two million cases, is 3.9 per 100,000. For comparison, the death rate for tonsillectomy is 5 per 100,000 and the death rate for appendectomy is 352 per 100,000. For legal abortions the rate is higher in women above 40 years of age, in non-white women, and when done past the first 12 weeks of pregnancy.

It is interesting to note the extreme criticism which is generated by the bureaucracy in regard to the Consumer Price Index for medical care which has elevated from 100 to 184.7 since 1967. One never hears a bureaucrat reacting to the increase of postal charges from 100 to 222.3 and the same for Social Security tax index from 100 to 332.4. Non-governmental items are up more than medical care—to wit: repainting the house 225.6, reshingling the house 233.4, repairing the auto 189.7, and the price of bathroom tissue 234.4. All quoted increases are for the same period.

A letter to the editor of "The Western Journal of Medicine" by Angelo J. Leoni, M.D., points out that there are two types of "preventive medicine." One type deals with sanitation, immunization and disease prevention by use of drugs. This type the physician handles well. The other type is not true preventive medicine. It is more accurately termed behavior change or behavior modification. It has to do with avoidance of habits like drinking too much, eating too much, smoking, and careless driving. Physicians have little or no control over this situation. If patients did



their own preventive medicine in this category, everyone would be healthier. The public should be educated as to who is responsible for prevention.

Upjohn's "Guidelines to Metabolic Therapy" reports that children with carbohydrate intolerance who benefited while receiving oral anti-diabetic agents and whose carbohydrate intolerance improved showed regression of thickening of muscle capillary basement membranes. In contrast, those who did not improve carbohydrate tolerance showed increased thickening of basement membranes. The researchers concluded from these data that careful control of a diabetic patient's blood sugar should pay dividends by way of prevention of cardiovascular complications.

Jefferson Medical College is testing a new electron radiography machine designed to take breast x-rays at radiation doses 10 times less than the average machine now in use. The image is registered by a technic similar to everyday paper copying machines. X-ray film is not necessary.

The Michigan Health Council reports in the daily press that Michigan has lost 3,506 of its licensed doctors in the past year. This is a 22% reduction and is thought to be due to a variety of causes such as the state's new continuing education requirement, the single business tax and high malpractice insurance rates.

The VA may give a grant of up to \$25,000 to a disabled veteran who needs a "wheelchair home." The grant can be applied to a new home, used to remodel an existing dwelling or to pay off the balance owing on a home the veteran has modified as his own expense. The grant consists of up to half the cost of the specially adapted home to a maximum of \$25,000.

Hoffmann-La Roche's Vitamin Information Program has reached more than 16 million people since it began in October. Originated to counteract people's vitamin misinformation, the program has been carried in newspapers, and by television and radio. Vitamin-related articles have been published by more than 260 publications.

Dr. Stephen K. Carter, research oncologist, Stanford Research Institute, reports that about one third of the people in the U.S. who develop cancer are being cured and that advanced therapy is now available to cure as many as one half of these patients. First priority in research, he says, is the development of a skin test for malignancy. Thoroughgoing treatment in the non-symptomatic stage is the answer to cancer.

An AMA survey reveals that about 17 million house calls are made by physicians in the U.S. each year. The main reason there are not more is the relative importance of the office or hospital from a diag-

nostic viewpoint as compared with the past. On an income basis, more house calls are made to the low income group. On the basis of the patient's age, most house calls are made to the elderly.

If the index of the cost of medical practice moved in proportion to the Consumer Price Index, physicians' fees would all be lower. The AMA reports that during most of 1971-74 doctor fees were controlled. Doctors' business costs in the same period went up by 18.5%—fees went up by 16.3%, doctors' income per patient was up by 14.7% and the cost of living went up by 21.8%—physicians' purchasing power actually fell. After controls went off the cost of doing business rose by 12.3%, fees rose by 12.3% and physicians' income per patient rose by 12.2%. Malpractice insurance rates are a major factor. The increase in physicians' fees is less than the increase in business expenses and physician income has risen less than the cost of living.

Milton Friedman, Ph.D., 1976 Nobel Prize winner in Economics, thinks the present trend toward ever greater government involvement in health care is against the interests of patients, physicians and hospital personnel. He states that the initial effect of government participation is to increase hospital and doctor expenditures. However, when government control becomes nearly complete, expenditures will shrink and other facets of medical care suffer.

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Increased Health Care Spending — A Closer Look at the Causes

JOHN R. VIRT, Ph.D.
Indianapolis

FROM fiscal year 1965 to fiscal year 1975, the amount spent by this country for health care increased \$83.3 billion and grew to amount to 8.4 percent of our gross national product. Consequently, legislators, businessmen, politicians, economists, and government analysts and administrators have expressed great concern, and some have prescribed measures which they believed would correct the "problem." Unfortunately, such suggested remedies are often given serious consideration by public policy makers without a close look at the causes and sources of increased spending.

Most evidence available and utilized by both sides in today's debate about medical care and "health care policy" is anecdotal, apparently because of the nature of the subject rather than any lack of skill or knowledge on the part of the debaters. However, certain empirical studies can be done. This article discusses the results of some preliminary measurements made from a macro, or global, look at U.S. health care expenditures on the hypothesis that the bulk of the increase in spending in the 1965-1975 decade can be accounted for by either:

1. Forces external to the health care industry, or
2. Long-established trends within

the markets for health care goods and services, which are consistent with the concepts of consumer sovereignty, competition, and social welfare in a free society.

If the hypothesis is valid, there is clearly a need for further study before public policy is implemented to bring greater government intervention or control into our health care system. In addition, a better understanding must be sought of the forces that influence those costs before any decisions are made about the direction of public policy.

The forces at work on health care spending have been social, demographic, legal, governmental, and economic as well as medical-scientific. Beyond these, there remains an unexplained amount generated by other factors. The reader will have to judge for himself the quality and usefulness of individual estimates. Nevertheless, if the pattern of analysis discussed here is accepted as valid and meaningful, it may prompt research groups both inside and outside government to undertake more study of the problems.

Probably the best way to understand where we have been, where we are, and where we seem to be going in health care spending is to start by acknowledging two basic facts that underlie our system:

1. Our society seeks health care as a "solution" to such problems as malnutrition, accidents, violence, and tension, even though specific medical care actually represents a rather inefficient approach to such problems, and
2. A part of our spending (e.g., for birth control, abortion, custodial care) cannot be expected

to have a significant effect on the objective health status of our population. Another substantial part (essentially all medically related research and development activities) cannot be expected to have an immediate impact on health care.

In addition, four other characteristics often have been used to describe our system:

1. He who prescribes does not pay; he who pays does not choose the mode of treatment;
2. Third-party systems tend to reduce financial constraints and, thus, cost-effectiveness consciousness for both providers and patients;
3. There has been a near explosion of medical technology since World War II, a great deal of which has tended to increase costs of health care—in contrast to the apparent results of new technology and innovation in other sectors of the economy; and
4. The markets for medical care are different from typical markets for consumer goods and services—not only because of the institutional factors but also because of the difficulty of defining and placing a value on outputs rather than inputs. The productivity or cost-effectiveness of medical care is, therefore, very hard to measure.

Although these characteristics are significant in shaping the economics of medical care and the expenditure levels and patterns for goods and services, each has another side to it that is frequently overlooked. These might be stated as follows:

1. In no other area of consumer

Dr. Virts is corporate staff economist with Eli Lilly and Company.

Adapted from the study "U.S. Health Care Spending: An Alternative Analysis of Increases," presented before the American Enterprise Institute Seminar on Regulation, Washington, D.C., July 22, 1976.

TABLE 1

	FY1965	FY1975	Increase	% Increase	Growth Factor
U.S. total health expenditures	\$ 38.9 billion	\$122.2 billion	\$ 83.3 billion	214.3%	3.143
Population	196.7 million	216.6 million	20 million	10.1%	1.101
CPI medical care price index (1967 = 100)	88.3	160.2		81.5%	1.815
Per capita consumption (in FY1965 dollars)	\$197.75	\$310.93	\$113.18	57.2%	1.572

decision making does the consumer have such highly trained and professionally motivated "purchasing agents."

2. Financial constraints are not altogether absent. They do not necessarily have to be present in the *entire* market for prices and quantities to respond reasonably efficiently, in keeping with a resource allocation that is consistent with "operable" consumer sovereignty. Moreover, both provider and patient face nonfinancial constraints even in a zero-price environment. These are imposed on providers by professional considerations and peer pressure, and on patients by time-trouble-discomfort costs.

3. In every line of economic endeavor, some new technology leads to innovation that reduces costs while other new technology opens additional markets. When technology is changing rapidly and the development stage is long, fraught with uncertainty, and perhaps truly optimal only in relation to very specific potential health problems and characteristics of 220 million human beings, it is reasonable to expect differences in professional opinion about the relationship of new technology to cost-effective innovation. Decision makers on medical care still have available the alternative technology of two, ten, or one hundred years ago—if they lay professional and legal constraints aside. However, it seems very doubtful that *any* physician, pharmacist, or nurse would consider practicing today with the technology of even five years ago. This, therefore, is evidence that results of the *proc-*

ess of technologic development in medical care have added something positive in their professional judgment. We all face the age-old problem of knowing that 50 percent is wasted but not knowing which half is which. Furthermore, there is no true, objective consensus of what the "output" of the explicit medical care process is supposed to be.

4. Every market is different from every other market. Such differences require flexibility, care, and selectivity in tools chosen for analysis. If the basic tenets of market orientation, private ownership, and free enterprise are accepted as the imperfect but best available guidelines to individual freedom in economic development, then differences in markets call for a tailored analysis of behavior and performance. The viability of market orientation should not be rejected for those markets which differ from some concept of normality or for which analysis may be especially difficult.

The Basic Sources of Increased Health Care Spending

Since Medicare-Medicaid repre-

sented a substantial change in our nation's system of financing health care, any study of today's patterns should begin before these programs were implemented. Table 1 provides the necessary data required to calculate the increase in spending attributable to population growth, price inflation, and the combination of greater utilization of and quality improvements in health care during the period of fiscal year 1965 to fiscal year 1975.

Total spending in 1975 can be viewed as the product of 1965 per capita spending (in 1965 dollars), the 1975 population, the increase in prices, and the increase in utilization. This can be represented symbolically:

$$\$122.2 \text{ billion} = \$197.75 \times 216.6 \text{ million} \times 1.815 \times 1.572$$

On this basis, the *increase* in spending can be viewed as the product of the *increases* in per capita consumption, price, and population. This permits calculation of the amount due to each factor.

Table 2 illustrates the results of such calculations, utilizing the methodology most used by the Social Security Administration and other

TABLE 2

	Contribution to Increase FY1965-FY1975	
	Percent	Dollars
Population growth	8.4%	\$ 7.0 billion
Inflation	52.1%	43.4 billion
Utilization increase and quality improvement	39.5%	32.9 billion
U.S. total health expenditures increase	100.0%	\$83.3 billion

analysts. Approximately 8 percent of the total increase came simply from a larger population.

Inflation of Medical Care Goods and Services Prices

All consumer prices rose from 1965 to 1975. In such an inflationary period, one would expect medical care prices to rise. The CPI for consumer goods (less medical care goods) rose 60.4 percent from fiscal year 1965 to fiscal year 1975. The CPI for all services (less medical care services) rose 71.7 percent during the decade. Within the CPI for medical care, goods are weighted at about 17 percent and services at about 83 percent. Since medical care is a relatively small sector of the economy and since price measurements for this sector are all "input" prices, there is no reason to expect that prices here should have risen less than those in the rest of the economy. The expected increase can thus be calculated by using the above parts of the CPI with medical care prices removed and then using the medical care mix of goods and services. The "general inflation" index for medical care prices was 169.8 for fiscal year 1975 (fiscal year 1965 = 100). Since medical care prices actually rose 81.5 percent during the period, the CPI index for medical care was 6.9 percent higher than should have been expected from general inflationary forces alone. Symbolically:

Medical Care CPI = General Inflation Index * X
Specific Medical Care Inflation 181.5 = 169.8 x 1.069
(*with medical goods and services weights)

With this approach, the contribution of inflation to the increase in medical care spending from 1965 to 1975 can be broken down as shown in Table 3. In other words, if the government's fiscal and monetary policies had prevented all general inflation, special forces acting on medical care prices would have caused expenditures for those goods and services to increase by \$4.8 billion during the decade. This is approximately 4 percent of the \$122.2 billion spent in fiscal year

TABLE 3

General inflation	\$38.6 billion	
Additional specific medical care price inflation	4.8 billion	
	<u>\$43.4 billion</u>	(see Table 2)

TABLE 4

Malpractice premiums	\$1 billion	
More and more highly paid doctors in training	0.3 billion	
Increased administrative costs	1 billion	
Unexplained	2.5 billion	
	<u>\$4.8 billion</u>	(see Table 3)

1975 and 6 percent of the increase in spending being examined here.

Among the special forces acting on medical care prices during the decade were the rapid growth of malpractice legal actions and the accompanying increase in both usage of and premiums for malpractice insurance. Such premiums advanced from about \$180 million in 1965 to well over \$1 billion in 1975. These costs were, of necessity, "passed through" to consumers via medical care prices and, therefore, account for \$1 billion of the "specific medical care price inflation."

The total professional incomes of virtually all interns and residents in the U.S. system appear as hospital costs. Since all such expenditures are passed through to hospital prices, any increases contribute to the specific medical care inflation. The number of such physicians in training rose from about 42,700 in 1965 to approximately 63,700 in 1975, an increase of about 16,700 beyond that expected from

population growth alone. The increase was stimulated, at least partly, by explicit federal initiatives. The average annual pay of such professionals also rose much faster than inflation, growing from \$3,870 to \$7,360 in fiscal year 1965 dollars. The total resultant contribution to medical care inflation would appear to have been about \$300 million.

Every physician and hospital has had additional paperwork due to Medicare and Medicaid and the changing requirements of private insurance carriers. Providers have employed people to handle such administrative burdens, and the costs have been passed through as price increases. If the average hospital added two bookkeepers and the average physician 0.455 such persons since 1965—and if such positions paid \$8,000 in 1975—the total contribution to specific medical care inflation was about \$1 billion.

The possible sources of specific medical care inflation are summarized in Table 4.

Much has been written about the "rapid" rise in medical care prices. These increases have been labeled as "out of control" or, alternatively, have been attributed to greater demand resulting from third-party payment systems (such as Medicare-Medicaid or employer-sponsored group programs). Whatever the source of such unexplained specific inflation, it has accounted for some \$2.5 billion (or 3.0 percent) of the spending increase during the decade. Undoubtedly, some part of this \$2.5 billion resulted from increases in real demand generated by Medicare and Medicaid in the face of relatively inelastic short-term supply.

Income Growth

Spending generated by greater "utilization" of medical care goods and services is influenced by the growth in household incomes available for purchasing all sorts of goods and services. Since disposable per capita income increased 21.4 percent from fiscal year 1965 to

fiscal year 1975, we would expect that some portion of the \$32.9 billion increase in health care utilization came from the simple fact that people had higher incomes.

Economists say a consumer good or service is "relatively income elastic" if it stimulates a spending increase greater, in percentage terms, than any increase in consumer income itself. In this sense, medical care spending has been identified by some economic theorists as relatively income elastic. If health care expenditures are relatively income elastic, the expected increase would be no less than \$8.3 billion, which is 21.4 percent of fiscal year 1965 health spending.

Slowly Increasing Average Age of the U.S. Population

It is well known that advancing age enhances the need for and consumption of health care. In fiscal year 1965, the proportion of the total population sixty-five years of age or older was 9.55 percent, whereas it was 10.2 percent in 1975. Using the 1965 data on real per capita spending by age group, one finds that a 1965 population with the 1975 proportion of older citizens would have spent about \$230 million (in 1965 dollars and health care patterns) more for health care than was actually recorded. Such increased spending is part of the 1975 pattern.

The Growth in Expenditures for Custodial Care

Unlike the health spending statistics for some other countries, U.S. statistics include all expenditures within "nursing homes."

Over the 1965-1975 decade, expenditures for such care expanded markedly. Although they include the cost of some new technology applied to custodial care and a consequent increase in quality, most of the increase was due to a general tendency to shift care of the sick and aged from family dwellings to nursing homes. Payment for such services also tended more and more to be made through third-party systems.

To avoid double counting in estimating the impact of this process, one needs to correct the increase in overall nursing home costs for both population factors (aging and growth) and inflation. Such a procedure reveals a spending increase over the decade of about \$3 billion from the "monetization" of services previously supplied outside formal health care channels.

The Practice of "Defensive Medicine"

A result of widespread malpractice suits is the practice of so-called defensive medicine to protect particularly the physician and the hospital in case of court actions. It is thought that more procedures, more hospitalization, and more goods and services are used in this environment. Although the magnitude of such extra expenditures is not known with any precision, it has been reported by Dr. Roger O. Egeberg (coordinator of the DHEW effort to study the problem) to range from \$2 to \$10 billion in time periods close to 1975. A conservative estimate of \$4.5 billion (the average of the two lower of three estimates reported by Dr. Egeberg) may not be an unreasonable figure for a preliminary analysis. Since the practice of defensive medicine really began after 1965, the entire cost is assumed to be part of the greater utilization of health care goods and services.

Medicare-Medicaid

The institution of Medicare and Medicaid (as well as the growth in private forms of third-party payment) increased the utilization of health care goods and services in several ways beyond those already estimated:

1. People received more diagnosis and treatment for more conditions than they otherwise would have, because Medicare and Medicaid were designed to achieve such "new consumption." Fairly significant management inefficiencies also were associated with the Medicaid programs in various states.

2. The administrative costs of providers were increased over those of earlier periods (estimated above as a \$1 billion contribution to specific medical care inflation).

3. Since state and federal administrative costs for the programs are included in health care spending statistics for fiscal year 1975, these costs must be reckoned as part of the increase in utilization.

It should be noted further that Medicare and Medicaid have caused a shift in expenditures from the target populations to federal, state, and local governments. In addition, the programs have "monetized" some 1965-1975 consumption that was achieved in earlier periods through "charity" or "bad debts."

Two parts of the contribution of Medicare and Medicaid to increased utilization in fiscal year 1975 are capable of reasonably founded empirical estimation:

1. SSA data show \$1.1 billion as the federal and state costs for administering the programs. Such administrative costs appear as increased utilization of health care regardless of their actual contribution to patient care.

2. The management of Medicaid programs has also been somewhat inefficient. Use by ineligible persons and overcharging have been common occurrences. To estimate the impact of these forces on increased spending, one state with a well-managed program providing quality care can be used as a model and its cost experience compared with that of all Medicaid recipients in the national program. On the basis of qualitative assessments in the public record, the Texas program would seem to represent a reasonable model, since it has apparently achieved a balance between the interests of recipients, tax payers, and providers. If all state programs were monitored and managed as well as the one in Texas, a saving of nearly \$1.2 billion in the national Medicaid program might be achieved

with no significant reduction in the quality of care provided.

Summary of Identified and Quantified Causes of Increased Health Care Spending

Table 5 groups the various causes of increased spending into three major categories (price inflation, population change, and increased utilization of health care goods and services) and lists the dollar contribution of each. Because these data are difficult, the breakdown in Table 6 may be more useful for public policy purposes:

Unquantified but Identified Causes of Increased Spending for Health Care

The \$14.6 billion of increased "utilization and improved quality" left unaccounted for in the analysis represents about 17.5 percent of the total increase in medical care spending from fiscal year 1965 to fiscal year 1975 and about 12 percent of total fiscal year 1975 expenditures. This figure could increase or decrease, of course, through estimating errors in the quantified portions of the analysis. Nevertheless, the amount might be attributed to at least the following programs, data characteristics, and various socioeconomic forces:

1. New government programs for such diverse items as hospital construction and kidney dialysis have added, in one way or another, to total expenditures for health care.
2. The analysis of medical care spending is complicated by the fact that only input—not output—prices can be measured. It is virtually impossible to define and study "output" when dealing with such things as greater relief from pain, a quicker recovery, or a longer life. Thus, many improvements in quality and productivity must be left out of the calculations.
3. The purpose of Medicare-Medicaid was to provide more effective health care for certain target populations. This brought an increase in consumption that rep-

TABLE 5

Sources of Increased U.S. Health Care Spending (FY1965-FY1975) (in billions of dollars)

Price inflation for medical care goods and services		
General inflation*		\$38.6
Malpractice insurance premiums		1.0
Hospital costs for interns and residents		0.3
Hospital and physician administrative costs		1.0
Other medical care price increases†		2.5
		\$43.4 billion
Population Characteristics		
Population growth		\$ 7.0
Population aging		0.2
		\$ 7.2 billion
Per capita "utilization" of health care		
Not principally medical or health system related		
Because of income growth	\$ 8.3	
Custodial care "monetization"	3.0	
"Defensive medicine"	4.5	
		Subtotal \$15.8
Medical or health system related		
Government program related		
Medicaid inefficiencies	\$1.2	
Government administration	1.1	
"New" consumption	?	
Private sector related		
New technology	?	
Private third-party payments	?	
		Subtotal \$16.9
		\$32.7 billion
		Total \$83.3 billion

*Excluding medical care goods and services. Based on CPI data for goods and services weighted as they are in the CPI for medical care.

†Possibly due to the demand growth induced by Medicare and Medicaid in the face of relatively short-term inelastic supply.

TABLE 6

Causes of Increased U.S. Health Care Spending (FY 1965-FY1975) (in billions of dollars)

External to health care system		Within health care or unidentified	
Inflation	\$40.6	Specific medical care goods and services	
Population changes	7.2	price inflation ^b	\$ 2.8
Income growth	8.3	Other factors ^c	14.6
Institutional changes	7.5		
Government program costs ^a	2.3		
			\$17.4
	\$65.9		
	Total Increases \$83.3 billion		

^aAdministrative costs and induced inefficiency.

^bAssumes that the costs associated with higher-paid and greater numbers of interns and residents were generated within the health care systems.

analysis above.

^cClassified as "within health care" because the sources or cause is not quantified by analysis above.

resents a significant part of the \$14.6 billion of unallocated spending. Actually, the more successful these programs are, the more they contribute to increased spending for health care.

4. "Technology change" also played a role in the spending increase. Some new devices, procedures, or goods (such as drugs) represented more efficient replacements for older items or systems and thus tended to increase health care productivity. Other developments, however, added directly to expenditures, because the diagnosis or treatment was previously not available (e.g., brain scans or cobalt treatment). Much research and development are also carried on in institutions that provide care or goods used in care. Most expenses of this kind are passed through to health care prices. The increase in spending for new or more medically effective technology (in the sense of patient safety, comfort, or recovery) has been very substantial over the last decade. Such technology may or may not appear to be "financially efficient" if we employ the usual methods of analysis. However, the use of these techniques does represent a direct expression of consumer sovereignty. *All* such expenditures for new technology, whether cost-effective or not, appear as "increased utilization" and represent the most important quality—expenditure for medical care.

5. Third-party payment systems weakened the financial constraints on both patients and providers and thus added to the utilization of medical care. The total demand induced by these forces is not known with any precision. From 1965 to 1975, however, third-party payments grew from 47.5 to 67.4 percent of total health care expenditures. Weakened financial constraints also had an impact on other factors, such as the use of custodial care and the tendency to practice de-

fensive medicine. Nonetheless, there is always a time-trouble cost to patients seeking medical care. In addition, the provider professions—particularly physicians—are bound, to some extent, by professional ethics and peer pressure. Consequently, it is possible that the role of weakened financial constraints in increased spending has been overstated in recent years.

To get a "feel" for how important these five factors might be to the \$14.6 billion residual, some rough estimates can be made. If, for example, the consumption increases sought by Medicare and Medicaid were 20 percent and 50 percent respectively, this would account for \$4.8 billion of the \$14.6 billion total. Our best historic estimate of income elasticity for health care is 1.29. If we attribute the 0.29 portion of the increased demand to the pull of new technology, then \$2.4 billion is a reasonable estimate of higher expenditures from this source. As you will note, the estimates for Medicare-Medicaid new consumption and new technology have accounted for \$7.2 billion of the \$14.6 billion residual. This result is based partly on intuition and partly on sheer guess. However, it should at least emphasize that such forces as weakened financial constraints may be of less significance to past increases in spending than was presumed by some analysts. It might even be argued that the current combination of market forces plus financial and nonfinancial constraints still provides a reasonable balance between cost-effective medicine and the needs and desires of consumers.

Conclusion

Since this macro analysis focuses on aggregate expenditure changes in a specific time period, it can give only a limited view of any particular aspect of the basic economic structure of health care institutions. Broadly interpreted, these preliminary results would seem to deny either satisfaction with the status quo or the need for crisis responses.

If the data presented here are at all valid, then U.S. health care costs do not seem to be out of control in any special sense that calls for dramatic public policy initiatives. This is not to say, however, that there is no room for improvement. Several obvious areas needing immediate attention are the malpractice situation, the administration of Medicare and Medicaid, public education in utilizing health care, and the use and administration of private insurance. Yet, if the goal is to control costs, this study does seem to belie the wisdom of bringing either the provision or financing of health care under greater government control. Indeed, the data could easily be interpreted as showing a need for less rather than more government intervention in health care.

Even though only preliminary, these data and this analysis must lead to a strong conclusion that much more study is needed, in directions somewhat different from past directions, before public policy conclusions are drawn. The implications for any national health insurance proposal are very important. Government controls in any system as complex as health care have far-reaching effects difficult to foresee. It is essential that we develop a clearer understanding of the existing forces that influence health care costs before we decide on any direction for public policy.

Research into the economics of health care must continue. The results of the analysis reported here would seem to suggest investigation in at least the following directions:

1. An in-depth critique and extension of the estimates and analysis presented above.
2. An empirical study, possibly econometric, of the income elasticity of medical care spending (i.e., the relation between income and spending with all relevant price effects and income subsidizations accounted for). Most important, this investigation should be expanded to evaluate whether such elasticity is consistent with operable consumer sovereignty.

3. An analysis of the data bases used to calculate health care spending in other countries. This should be accompanied by an in-depth study of the economic, demographic, medical, legal, and governmental forces that have caused such outlays. It is as important to understand these

spending levels and social forces as it is to understand similar events in our own country. International comparisons, after all, have been an important part of the rhetoric for increased government intervention.

4. A sector-by-sector study of U.S. health care spending to

identify and quantify the causes of expenditure growth.

A copy of the complete study, "U.S. Health Care Spending: An Alternative Analysis of Increases," is available upon request to the author. ◀

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BOOK REVIEWS

REVIEW OF MEDICAL MICROBIOLOGY, 12TH EDITION

E. Jawetz, J. L. Melnick and A. E. Adelberg, Lange Medical Publications, Los Altos, California 94022, 1976.

This comprehensive review, presented in sturdy paperback style, is another winner produced by the Lange people; a worthy companion to *Current Medical Diagnosis and Treatment* edited by Krupp and Chatton. While it gives specific directions for the isolation and cultivation of micro-organisms it is not in any sense merely a handbook for laboratory technicians. It deals in some detail and obvious authenticity with the fundamentals required for proper understanding of infectious diseases and their management.

In the chapter on antimicrobial chemotherapy, an excellent discussion points out the various ways in which antimicrobial agents attack microorganisms at the various sites in which they are vulnerable, and explains the origin of drug resistance. The drug-parasite relationships which affect the outcome are also discussed before each antibacterial agent is described and its particular usefulness outlined.

The book will be especially useful to students because it reviews other fields in which they are immersed and relates them to infectious disease. This is not a text on immunology but newer developments in diagnosis, prognosis and treatment of infectious disease as they depend on immunologic mechanisms are quite adequately presented.

This reviewer was particularly impressed with the section on microbial genetics. For older clinicians this will be hard going but one must try to get familiar with the newer concepts and vocabulary. Even though genetics as a discipline was slow to work its way into medical school curricula, its importance in all clinical fields is too important to be neglected.

Cell mutations, so important in frustrating antibacterial therapy, cannot be understood without some background knowledge of genetics.

Viruses are dealt with adequately. The ones known or strongly suspected to be important in causing cancer should be of special interest to clinicians.

Taken altogether, this volume on microbiology by Jawetz and his collaborators can be heartily recommended to all clinicians and all medical students. The breadth of its coverage and the lucid relation of basic knowledge to the recognition and treatment, both preventive and curative, of infectious disease could have been produced only by scholars who also know how to deal with patients.

PAUL S. RHOADS, M.D.
Richmond, Indiana

LIVE LONGER NOW

Jon N. Leonard, J. L. Hofer, Nathan Pritikin, Grosset & Dunlap, New York, 1974; \$2.95 in paperback

Live Longer Now, written for the general reading public, concerns itself with the degenerative diseases and with a program designed to promote good health, involving primarily changes in diet and exercise. The book properly criticizes the lifestyle of most Americans in regard to these areas. It impresses this reviewer as an informative, common sense guide that can be recommended to the average layman. The book is paperback and sells for \$2.95.

W. D. SNIVELY, JR., M.D.
Evansville

THE LIVE LONGER NOW COOKBOOK

Jon N. Leonard, Elaine Taylor, Grosset & Dunlap, New York, 1977; \$12.95.

The Live Longer Now Cookbook is, in a sense, a sequel to *Live Longer Now*. It presents nearly 600 readily prepared recipes designed to help prevent various degenerative diseases. Attention is focused on the dangers of the high-fat diet, which is usually also high in cholesterol and saturated fatty acids. The dangers of excessive sodium intake are also stressed. Recipes include appetizers, soups, stews, homemade breads, sandwiches and dishes for breakfast. The book is hard cover and sells for \$12.95. It can be recommended for individuals interested in making a painless and pleasant transition to more rational dietary habits.

W. D. SNIVELY, JR., M.D.
Evansville

PAIN: A PERSONAL EXPERIENCE

J. Blair Pace, M.D., Nelson-Hall, Chicago, 1976; 158 pages, with illustrations, \$7.95.

This excellent book was written primarily for the layman, but it can be highly recommended for any physician treating patients with pain. The main point of the book is that the treatment should be directed toward the patient, not toward the pain. This book reflects the experience Dr. Pace has had at the Problem Back, Chronic Pain Unit at Rancho Los Amigos Hospital, Downey, California. Dr. Pace points out that pain is purely a personal and subjective experience and that the manner in which an individual reacts to pain is dependent on many factors, ranging from cultural and ethnic backgrounds to the secondary gain generated by the pain.

The mental state of the individual is of prime importance in his reactions to pain. Is there anxiety or depression present? Is the pain a defense mechanism? Does it produce sympathy? An understanding of these factors is important to both the patient with pain and to his physician.

The last half of the book discusses some specific types of pain, including headache and back pain. There are brief references to unorthodox healing technics in the management of pain.

The physician may want to get more than one copy of the book, so that he can encourage his patients with chronic pain to read it.

ELTON HEATON, M.D.
Madison

CURRENT MEDICAL DIAGNOSIS AND TREATMENT

Edited by Marcus A. Krupp and Milton J. Chatton, Lange Medical Publications, Los Altos, California, 1977 edition; 1066 pages, paperback, \$16.00

The 1977 edition of *Current Medical Diagnosis and Treatment* is the 16th annual revision of this extremely useful volume produced by Krupp and Chatton of Stanford University School of Medicine and their colleagues. It fully lives up to the

Continued on page 604



"...Sleep that knits up the ravell'd sleeve of care..."

— WILLIAM SHAKESPEARE, *MACBETH*, ACT II, SC. 2

Insomnia

a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime.¹ Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information

ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response.

Usual optimum daily dosage is 75 mg to 150 mg per day, not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg and 50 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.

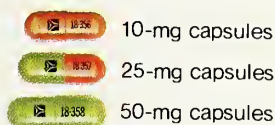


When they see life
in shades of blue...
help them see life
in all its colors.

Adapin®

(doxepin HCl)

single daily dose recommended h.s.



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reputation created by previous editions. In their foreword the editors state that the volume is intended to be a useful desk reference for the practicing physician and is not claimed to be a textbook of medicine. When one consults it he rarely fails to find the up-to-date factual material he is seeking. Although presented in fewer words, the information conveyed usually is as extensive and often more current than one finds in the larger textbooks of medicine.

The scope of the subjects covered is rather surprising. For instance, in an excellent section on diseases of the breast, one learns that when primary or metastatic breast cancer tissue has active estrogen receptor sites there is a 60% probability that they will regress in response to hormone manipulations such as ovariectomy, adrenalectomy, hypophysectomy or hormone administration. He learns further that the presence of estrogen receptors makes both estrogen and androgen administration more effective, provided the selection of hormones is properly made. The indications for each are thoroughly discussed.

In the chapter on medical genetics the various technics of prenatal diagnosis such as ultrasonic scanning, amniography and fetography and amniocentesis are described in enough detail to give one some idea of what can be accomplished even if technics are not detailed. For older clinicians, like this reviewer, the list of disorders which can be detected in utero is rather startling. Under "Malignant Disorders" paraneoplastic syndromes such as spinal cord compression, superior vena cava syndrome, hypercalcemia, hyperuricemia, sepsis in the compromised host under chemotherapy, etc., are described and logical treatment outlined.

The scope of practical information of the kind the active practitioner needs in his daily work, which this volume presents, is remarkable. I find that many senior medical students have this volume by Krupp and Chatton always in easy reach. My guess is that once physicians in active practice become acquainted with it they will acquire the same habit. It is up to date, each chapter is followed by good references. The book can be recommended in a completely unqualified way.

PAUL S. RHOADS, M.D.
Richmond, Indiana

DRUG REGULATION AND INNOVATION

Henry G. Grabowski, American Enterprise Institute for Public Policy Research, Washington, D.C., 1976; \$3.00 in paperback.

In *Drug Regulation and Innovation*, Henry Grabowski has examined recent studies on the effects of regulation on new product innovation, the rate of return on investment in research and development, the shift of research and development activity abroad by multinational firms, and the concentration of drug innovation in fewer and larger firms. Mr. Grabowski has inquired into a topic of great current interest, for there is a widespread feeling among physicians that excessive drug regulation in the United States has prevented the marketing of effective medications that are available to patients in most other countries. Grabowski, who is professor of economics at Duke University, presents convincing evidence that the Food and Drug Administration is, in effect, smothering new drug introduction. He points out that an FDA official takes great personal risks in granting approval for a new drug but risks almost nothing in denying approval. Grabowski, therefore, makes three suggestions to increase the FDA's accountability. *Drug Regulation and Innovation* is paperback and can be obtained for \$3 from American Enterprise Institute for Public Policy Research, 1150 Seventeenth St., N.W., Washington, D.C. 20036. It is recommended for physicians and other health workers con-

cerned with the stultifying effects of excessive bureaucratic regulation on new drug development.

W. D. SNIVELY, JR., M.D.
Evansville

SOLVED: THE RIDDLE OF HEART ATTACKS

Broda O. Barnes, M.D., Robinson Press, Fort Collins, Colo., 1976.

When a book purports to solve the riddle of heart attacks, it immediately becomes suspect. Too many outstanding investigators and clinicians are still deeply puzzled by the riddle of heart attacks. The author's solution to the riddle is to attribute heart attacks to hypothyroidism. There is no question that hypothyroidism favors atherosclerosis. The worst pipe-stem arteries this reviewer has ever seen were in a woman with myxedema. But the overwhelming majority of authorities agree that hypothyroidism is merely one contributing factor, not the solution to the riddle. The book cannot be recommended.

W. D. SNIVELY, JR., M.D.
Evansville

What's New in Books?

ANACOM, a division of American Management Associations, has released a new book—"Managing Non-profit Organizations." The motto is "Nonprofit Does Not Mean Non-Managed." 328 pages, \$16.95.

* * *

Lippincott has released "The Saturday Night Knife and Gun Club," a satire by B. P. Reiter, M.D. It is a fictional run-down on what an intern experiences in his first year at a New York City hospital. Described as grim and vicious but adequately relieved by humor which is its outstanding characteristic. Priced at \$8.95.

* * *

Anchor Press has released "99 Ways to a Simple Lifestyle," a 382-page paperback which outlines and explains methods of simplifying living with a view to saving money and energy without sacrificing satisfaction. Priced at \$3.50.

* * *

Dell Publishing announces "Menstruation and Menopause," by Paula Weidger. It has recently been revised and expanded to include information on estrogen replacement therapy. Saturday Evening Post says: "This book is a must for everyone, male and female, who seeks to understand the psychology and physiology of women." Price: \$4.95.

* * *

Van Nostrand Reinhold announces the release of "Psychosomatic Aspects of Allergy" by Claude A. Frazier, M.D. It is a practical guide to show physicians and patients how to cope with the emotional components of allergic disease. 252 pages. \$14.95.

* * *

Dell Books has the first paperback edition of "The Hite Report" scheduled for one million copies. The book is described as a controversial bestseller on women's attitudes toward sex. The price is \$2.75. ◀

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE **DYAZIDE®**

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

Warning

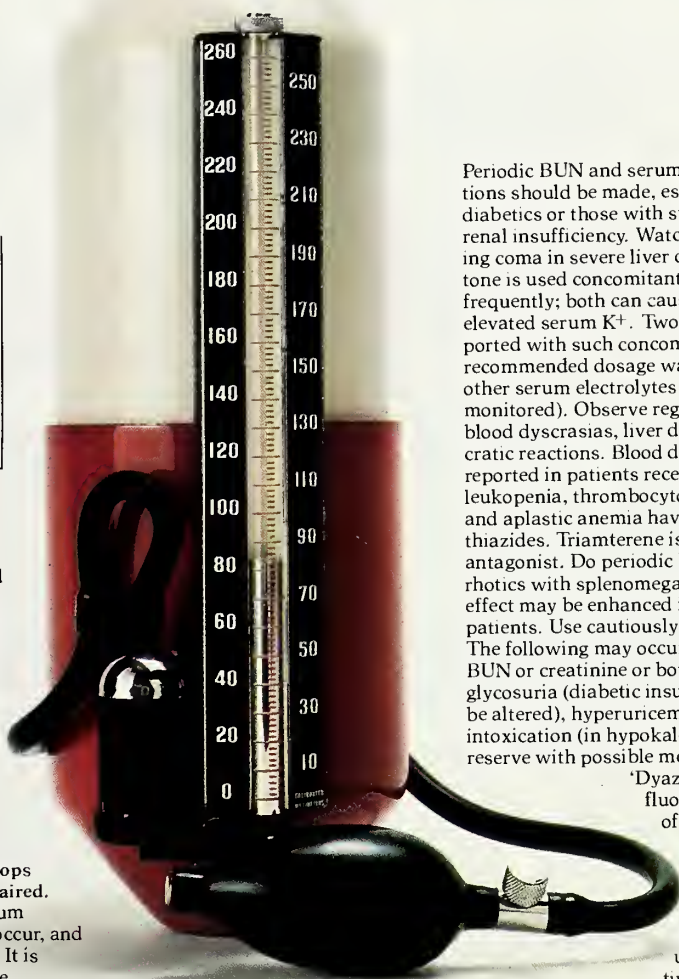
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).



**FOR LONG-TERM CONTROL
OF HYPERTENSION*
SERUM K^+ AND BUN SHOULD
BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)**

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

*Dyazide® interferes with fluorescent measurement of quinidine.

Adverse Reactions:

Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions;

nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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Gantanol[®] DS
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**double-strength dosage form
for acute cystitis* patients**

*nonobstructed; due to susceptible organisms

Gantanol® DS (sulfamethoxazole) tablets offer even greater convenience and economy for your patients with acute, obstructed cystitis due to susceptible strains of *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus*, *Proteus mirabilis* and, frequently, *Proteus vulgaris*...

For the same amount of medication, the same efficacy, with only *half* the number of tablets per day.

Simplified dosage regimen encourages patient compliance: 2 tablets (1 Gm each) B.I.D. for 10 to 14 days.

—then 1 tablet B.I.D. for 10 to 14 days. Clinical efficacy so basic you can start cystitis therapy even before culture results are available.

• In a clinical study of 406 patients on Gantanol (sulfamethoxazole) B.I.D., close to 9 out of 10 patients achieved negative urine cultures. While Gantanol tablets were used in this study, one Gantanol DS tablet has been proved bioequivalent to two Gantanol tablets.*

Gantanol is contraindicated during pregnancy, during the nursing period, and in infants under 2 months. During therapy, maintain adequate fluid intake, perform frequent CBC's and urinalyses with careful microscopic examination.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

and economy

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic urinary tract infection (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus*, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*), in the absence of obstructive uropathy or foreign bodies. Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms diminishes the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than 2 months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions (agranulocytosis, aplastic anemia and other blood dyscrasias) have been reported and early clinical signs (fever, throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under 2 years of age with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); allergic reactions (erythema multiforme, skin rashes, epidermal necrolysis, urticaria, serum sickness,

pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis). *Usual adult dosage:* 2 Gm (2 DS tabs or 4 tabs or 4 teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially; then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: DS (double strength) tablets, 1 Gm sulfamethoxazole; Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

Basic therapy with convenience and economy:

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and caffeine, 32 mg.



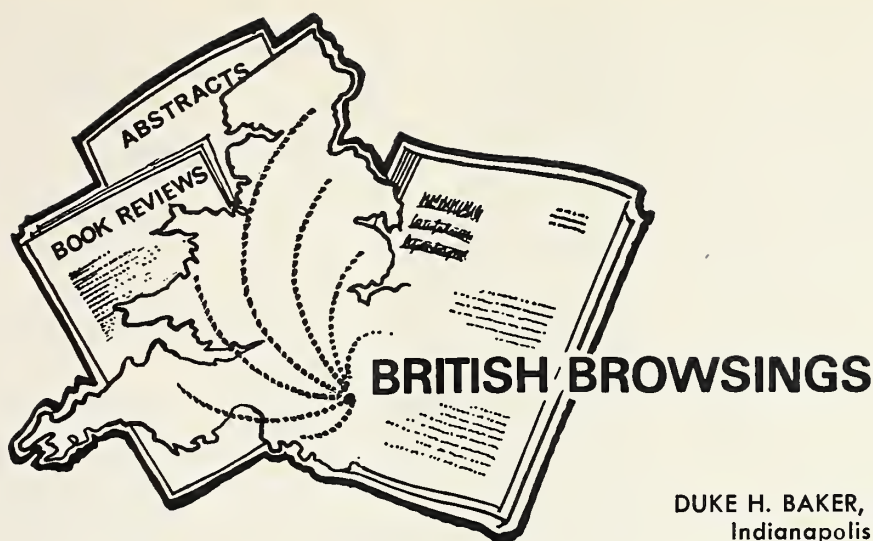
**EMPRACET[™]
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Each tablet contains:
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(Warning: May be habit-forming);
and acetaminophen 300 mg.



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DUKE H. BAKER, M.D.
Indianapolis

Edinburgh and Medical History

The Medical School

LAST year marked the 250th anniversary celebrations of the Edinburgh Faculty of Medicine. To help commemorate the year, the Royal Scottish Museum exhibited nearly 600 medical treasures, including the skeleton of William Burke, a notorious Edinburgh resurrectionist. The writer of a recent editorial in the *British Medical Journal* noted that

In 1726, under the influence of Leiden and of the two Edinburgh royal colleges, was initiated the first faculty of medicine in Britain to provide a full medical course with appropriate examinations.

The influence on world medicine of medical students who trained in Edinburgh has been immense. They can be numbered among the founders of the University of London, University College Medical School, the Middlesex Hospital Medical School, the modern St. Bartholomew's Hospital Medical School and the Royal Society of Medicine. In America Edinburgh graduates founded Philadelphia Medical School and King's College Medical School (Columbia), and influenced the medical schools in South Carolina, Maryland and Virginia. . . . Indeed, had not James Lind (who graduated in Edinburgh) shown how to prevent scurvy at sea, it is doubtful whether Captain Arthur Phillip, convinced by the experience of Captain Cook, would have reached Australia or whether it would have become a British possession.¹

An Edinburgh Medical Graduate

A biographical sketch of Dr. Benjamin Rush (1746-1813) was published recently in the *British Medical Journal*, excerpts of which follow here.

"The Father of American Medicine" was born in Philadelphia of English Quaker stock in 1746. Following graduation at Princeton in 1760, he began his medical studies as an apprentice to Dr. John Redman. Later he journeyed to the famed Medical School at Edinburgh and in 1768 graduated MD there. Returning to Philadelphia in 1769, he took up practice and was appointed professor of chemistry in the medical school there.

During the war years, Rush served in Congress and also as a surgeon-general in the newly created medical department of the army.

He must have been a compulsive writer; "ideas," he said, "whether acquired from books or by reflection, produce a plethora of the mind, which can only be relieved by depletion from the pen and tongue."

Rush pronounced on many topics—hygiene, tobacco, alcohol, capital punishment, the education of women and slavery. In 1794 came his celebrated account of the devastating epidemic of yellow fever in Philadelphia entitled "An Account of the Bilious Remitting Fever." His terrible therapeutic ritual of bleeding and purging for this disease was opposed at the time and has been condemned ever since.

One of Rush's most historically notable acts was that of signing the Declaration of Independence in

1776. The other four physicians were Josiah Bartlett of New Hampshire, Lyman Hall of Georgia, Matthew Thornton of New Hampshire and Oliver Wolcott of Connecticut.²

The Edinburgh Royal Infirmary a Century Ago

An article recently published in the *British Medical Journal* retells the personal account of the experiences of Margaret Mathewson as a patient at the Edinburgh Royal Infirmary. She was admitted about a hundred years ago, in March 1877, at age 29, suffering from a tuberculous infection of the shoulder joint. One month after she was admitted Lister, then professor of clinical surgery in Edinburgh, carried out an excision of the shoulder joint, and seven months later she was discharged from the infirmary; her state on discharge was optimistically entered in the hospital records as "relieved."

The patient noted on first entering the ward that it seemed "attractive and friendly." A large fire burned in the fireplace. The floor was made of wood except down the center of the ward were flagstones, on which stood a large table with lotion bottles and dressings at one end. There were a total of nine beds in the ward.

What now follows is an excerpt from her recollections of "a patient's day."

The day began early for the patients—at half-past five in the morning. Those who could get up were expected to make themselves useful in cleaning and tidying up the ward. After breakfast they were again set to work preparing dressings. Bundles of gauze had to be torn into strips 20 yards long of varying widths up to three inches to make bandages. For Lister's dressing technique many bandages were needed, and the rolled bandages were piled into baskets for use later in the day. At 10 o'clock patients began to arrive at the surgical block to see Lister, and between eleven and half-past there was great commotion as the medical staff and visiting doctors drove up to the door in their carriages, and students "by the score" walked down

from the college arm in arm. By noon quiet was restored. At that hour Lister, accompanied by his house surgeon and 40 or more students, visited the wards to examine patients and dress the major wounds. At about one o'clock Lister left the wards to go up to the theatre to operate or give one of his popular clinical lectures to the students. In the early afternoon the students employed as dressers undertook the dressing of both inpatients and outpatients, and at five o'clock visitors were admitted for an hour and a half, a bell being rung to tell them when it was time to leave. At a quarter to eight the staff nurse said prayers in the ward, and at eight o'clock all patients who were up returned to bed. At half past eight the night nurses came on duty, and thereafter the patients were expected to settle down to sleep.

Margaret was a little surprised that work continued on Sundays as on other

days. Indeed, it was Lister's custom to visit his wards each Sunday after morning service, and his dressers found this a valuable teaching session, for on these occasions they alone were with him, and there were no other students or distinguished visitors present.

So far as Margaret Mathewson was concerned Lister's operation proved remarkably successful, but the basic infection remained, and on 28 September 1880 she died of "consumption of the lung." As so often at that time, the tubercle bacillus had conquered in the end.³

REFERENCES

1. Edinburg and Medicine, editorial, *Br. Med. J.* 2:1276-1277, 1976.
2. Spillane, J.D.: Doctors of 1776-I, *Br. Med. J.* 1:1571-1574, 1976.
3. Howie, W.B.; Black, S.A.B.: Hospital Life a Century Ago, *Br. Med. J.* 2: 515-517, 1976. ◀

About Our Cover

At the bend of the Michigan City harbor stands an historic old structure whose beacon served as a guiding light for Great Lakes sailors for more than 100 years—The Old Lighthouse, built in 1858 and placed on the National Register of Historic Places in 1974 because of its historically significant architecture and association with lake transportation.

The first lighthouse, consisting of a keeper's dwelling with a 40-foot-high white-washed tower topped with a lantern to house the light (as depicted in the small sketch) was constructed in 1837.

As the shipping of grain and lumber increased, a brighter light was needed to guide the ships. In 1858 the U.S. Government constructed a lighthouse of stone and brick. The date of 1858 can still be seen on the south wall. On the north end of the lighthouse was the lantern which housed a fixed light with a Fresnel lens of the 5th order which could be seen for 15 miles. Sperm oil fueled the beacon.

Earliest known journals of the lighthouse keepers began in 1872 and from this record we find "Commenced using kerosene at Beacon, July 16, 1880." So diligently did the keepers perform their tasks, with many tales of bravery and heroism, that the Michigan City Lighthouse became known on the Great Lakes as "Old Faithful."

The dwelling, which served as the keeper's living quarters, was remodeled in 1904 and enlarged to make two apartments—one for the keeper and the other for the assistant keeper.

In October 1904 the lantern was moved to the new fog-signal lighthouse at the entrance of Michigan City's harbor where the French-made Fresnel lens from the 1858 lighthouse is still in use today.

A replica of the original lantern tower was placed on the roof of the Old Lighthouse and a light shines from it a few hours each night.

The Old Lighthouse is operated as a museum by the Michigan City Historical Society. It is open to the public Tuesdays through Sundays from 1 to 4 p.m. for a nominal admission fee. The Museum also houses medical displays relevant to Dr. A. L. Spinning and the Mullen Hospital and Dr. Alexander J. Mullen, Jr.



NEWS NOTES

Dr. Scamahorn Installed as President Of Indiana Academy of Family Physicians

At the recent annual meeting of the Indiana Academy of Family Physicians, **Dr. Malcolm O. Scamahorn, Pittsboro**, was installed as president, and **Dr. Paul A. Williams, Rensselaer**, was named president-elect. Serving with them will be **Dr. Ronald Blankenbaker, Indianapolis**, vice president; **Dr. George B. Keenan, Indianapolis**, treasurer; **Dr. John Saalwaechter, Lebanon**, speaker of the house, and **Richard G. Huber, Bedford**, vice speaker.

Dr. Robert Ward Named "Editor's Choice"

Dr. Robert A. Ward, Tell City, received the "Editor's Choice" award for his volunteer community work and became the Eighth Congressional District's finalist in a state competition that honors Vietnam veterans for their contributions in both military and civilian life. Dr. Ward spent a year in Vietnam's northern provinces and has been involved in community work with young people since returning to his practice.

Fund to Honor Dr. Hendricks

A memorial fund has been established by the family of **Dr. John Wesley Hendricks, Indianapolis** urologist who died May 28 in an auto accident.

An award will be made annually to Winona Memorial Hospital to further education and research or to enhance equipment at the hospital while enriching urology as a specialty. Contributions may be made through the Winona Memorial Foundation.

Conducts Workshop for Clergy

Clergy from 19 southern Indiana counties attended two workshops conducted recently at the Madison State Hospital. **Dr. Karleen B. Hammitt**, assistant superintendent, medical, for the hospital, was the workshop leader. Subject of the workshops was "Depression: A Pastoral Concern."

Two Elected to Foundation Board

Dr. Robert Maurer is president, and **Dr. Everett Conrad**, vice president, of the Clay Civic Memorial Foundation, Inc., which was organized to create a perpetual fund to benefit Brazil and Clay County. Purpose of the foundation is to enable all citizens of the community, plus outsiders who care to assist, to take the lead in raising funds to improve recreational facilities, beautify public places and implement other public projects which should not be the obligation of taxpayers or could not be done because of lack of tax funds.

Honor Six Grant County Physicians

More than 300 years of service to the residents of Grant County and dedication of the medical profession was

recognized at a recent dinner hosted by the Grant County Medical Society. Six physicians were honored.

Drs. Robert McIlwain and Grace Boyer, both general practitioners, and **Dr. Wendell W. Ayres**, a surgeon, received awards from the medical society and Marion General Hospital.

Posthumous awards were presented to the families of **Dr. Merrill S. Davis**, a surgeon; **Dr. Russell Lavengood**, a general practitioner, and **Dr. Eleanor McIlwain**, an ophthalmologist.

Tributes were paid to the Doctors McIlwain by **Dr. Russell M. Hummell**, to Dr. Davis by **Dr. John Pattison**, to Dr. Lavengood by **Dr. Larry Musselman**, to Dr. Boyer by **Dr. James E. Botkin**, and to Dr. Ayres by **Dr. E. C. Taylor**.

St. Paul Reduces Malpractice Rates

St. Paul Fire and Marine Insurance has reduced its medical malpractice rates for claims-made doctor policies in 17 of the 29 states where it is currently providing malpractice coverage. The rates in six states will be unchanged. Increased rates are necessary in six states. St. Paul believes the decrease, where attained, is due to loss-prevention effort of medical societies, to concern and commitment by doctors in controlling factors that produce claims, and to improving communication between doctor and patient.

Dr. Compton Elected to PMA Board

Dr. Walter A. Compton, Elkhart, chairman of Miles Laboratories, has been elected to the board of directors of the Pharmaceutical Manufacturers Association. **Richard D. Wood**, chairman of Eli Lilly & Company, was reelected a director.

Continued



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Searle Elects Rumsfeld President

Donald H. Rumsfeld, former secretary of defense, has been elected president and chief executive officer of G. D. Searle & Co. Daniel C. Searle, current chief executive officer, will be chairman of the board.

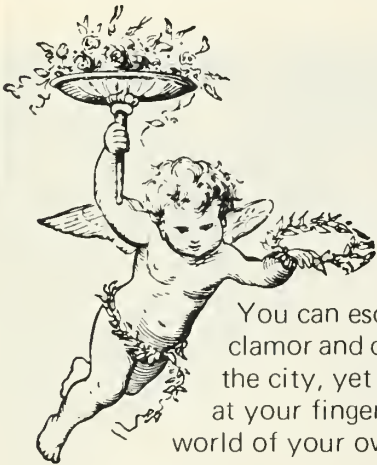
Medical Assistance to Travelers Overseas

The International Association for Medical Assistance to Travelers (IAMAT) maintains a directory of medical services overseas staffed with personnel conversant with English language. Membership is free. The organization is sustained by voluntary contributions which may be deducted on tax reports. Members are provided with a membership card, with a traveler clinical record and with world climate charts. The association is non-profit. It may be addressed for membership or donation purposes by writing to 350 Fifth Ave., Suite 5620, New York City 10001.

AMA Scholarship Honors Dr. Fishbein

The American Medical Association has established a fellowship in medical journalism to honor Dr. Morris Fishbein. It is open to physicians and to graduates of the life sciences. It provides \$18,000 for a 10-month training period with the publishing programs of the AMA.

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Physicians Attain Certification

The Journal has been notified of the certification of a number of Hoosier physicians by various medical specialty boards.

Dr. Daniel F. Cooper, Indianapolis, has been certified by The American Board of Neurological Surgery.

Dr. Thomas F. Lavelle, Jr., South Bend, was recently certified as a diplomate in the subspecialty of pulmonary disease.

Dr. Clifford W. Fiscus, Indianapolis, has been certified by the American Board of Ophthalmology.

Dr. Donald Hazelrigg has been certified by the American Board of Dermatology.

Hoosier Physicians Attain Fellowship

Drs. J. Stanley Hillis, Indianapolis, and Dr. Fred M. Kuipers, Lafayette, have been granted Fellowship in the American College of Cardiology.

Dr. Alan J. Habansky, Muncie, was made a Fellow of the American Academy of Orthopedic Surgeons recently.

Among Hoosier doctors elected to Fellowship in the American College of Physicians in April were the following: **Angenieta A. Biegel and Mark L. Dyken, Jr., of Indianapolis.**

Dr. Edmund A. Franken, Jr., Indianapolis, was named a Fellow of the American College of Radiology at the annual meeting of the College in Houston in April.

Dr. Lorin L. Lee, Indianapolis, has been elected to Fellowship in the American College of Obstetrics and Gynecology.

The American College of Surgeons recently inducted **Drs. Kenneth L. Nachtnebel and John D. Pulcini, of Evansville**, into Fellowship.

Continuing Medical Education

The following Indiana physicians are recent winners of the coveted AMA Physician's Recognition Award:

Howard M. Alig, Indianapolis
Bassem Atassi, Merrillville
Eliseo T. Banguis, Shelbyville
Mark M. Bevers, Seymour
Gregory L. Darrow, Terre Haute

Ted S. Doles, Middletown
George A. Donnally, Geneva
William A. Edwards, Danville
Isadore E. Friedman, Hammond

Marvin E. Gold, Valparaiso
Mark Gordon, Munster
David L. Gregory, Columbus
Charles G. Griffin, Valparaiso
J. Kent Guild, Plymouth
Charles F. Hagenow, LaPorte
William V. Hehemann, Munster

James E. Hinchin, Liberty
Mohammad R. A. Khairi, Indianapolis
Stanley H. Kryszek, Indianapolis
Charles J. Leiphart, Muncie
Donald L. McKinney, Otterbein

Woong K. Park, Marion
L. M. Pasilabban-Banguis, Shelbyville
Franklin F. Premuda, Hammond
Carl Rosenthal, Hammond
Henry J. Rusche, Evansville
Louis E. Schroder, Liberty
Jack Schwartz, Munster
Magda Schwartz, Hammond
E. Gregg Sheehan, Evansville
Michael Z. Silbert, Bloomington

John P. Smith, Fort Wayne
Ray C. Smith, Indianapolis
Terry A. South, Poseyville
John M. Thompson, South Bend

Richard E. Tielker, Fort Wayne
R. Wyatt Weaver, Angola
Jack G. Weinbaum, Terre Haute

Thomas E. Woerner, Indianapolis
Robert L. Young, Munster

Dr. Menninger Receives Lederle Award

Dr. Karl A. Menninger, popularly accepted as the founding father of modern American psychiatry, has become the first recipient of the Founders Award of the American Psychiatric Association. Lederle Laboratories is sponsor for the award. Dr. Menninger, who has practiced for more than 60 years, is still active in the affairs and practice of the Menninger Clinic.

Hartford Foundation Continues Grant

The John A. Hartford Foundation announces additional funding to Indiana University Foundation for "A search for evidence of cytoplasmic inheritance in man" by J. C. Christian. The grant has extended over several years. The sum of \$80,546 was paid during 1976.

Thyroid Symposium Proceedings Available

A complimentary copy of the proceedings of "Endocrine Update," a symposium dealing with recent advances in thyroid physiology, diagnosis and therapy, is now available on request to the Ames Company, Elkhart 46514. The symposium, held recently, had many prominent thyroidologists on its faculty.

Dr. Robertson Retires, Is Florida Bound

After 45 years of practice in Spiceland, **Dr. William S. Robertson** has closed his office. With his wife, he plans to live in Florida, where he hopes to continue his hobbies of golfing and cabinet-making.

Dr. Dickson's Painting Wins Award

"Nuts to You, Food for Me" was the whimsical title given by **Dr. Dale Dickson, Greensburg**, to the painting with which he won first prize at the recent Decatur County Community Artists open house.

Zaire Hospital Needs Surgeons

Indiana surgeons who will volunteer to spend at least four weeks working at the Wembo Nyama Hospital in Zaire are requested to contact the Reverend J. Kenneth Forbes, 1100 W. 42nd St., Indianapolis 46208. The hospital is supported by the United Methodist Church of Indiana, and the immediate need is for general practitioners who can perform surgery, in order to permit Dr. U. G. Wembodinga, African doctor at the hospital, to visit Indiana this year.

INDIANA MEDICAL BUREAU

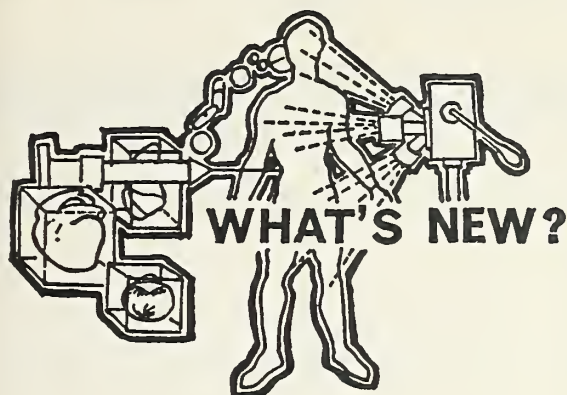
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A. H. Robins Company is introducing Z-BEC®, a high potency vitamin formula for adults. It combines zinc and Vitamin E with 600 mg of Vitamin C and a complex of B vitamins. Recommended for important roles in general nutrition, healing of wounds and prevention of hemorrhage.

The Venturi Company announces a new device to aid patients to break the nicotine habit. Nicotine produces a habit which is similar to that produced by heroin. The withdrawal symptoms in both instances are exceedingly uncomfortable. Gradual reduction of the nicotine dosage will accustom the patient to abstinence. The device consists of four cigarette filter holders which are distinguished by a color code and which are used one week at a time. The nicotine removing potential varies from 15% reduction for the first holder up to 95% reduction for the last one in the series. At the end of a month the patient is near enough to no nicotine to allow complete abstinence with minimal symptoms.

Norton, the "Tubing Professionals," has an eight-page bulletin describing its Tygone® flexible tubing with special formulations for medical and scientific applications. Two surgical and hospital tubing formulations meet perfusionists' requirements and are available in sterile packaging.

Endo Laboratories is introducing AZENE™ (clorazepate monopotassium), a benzodiazepine indicated for treatment of clinically manifest neurotic anxiety, psychoneurotic anxiety and anxiety associated with somatic disease. Dosage options, depending on the patient's need, are a single daily nighttime dose or divided daily doses.

The National Gender Selection Center has a gender selection kit, which enables parents to preselect, before conception, the gender of their planned child. It is the result of years of research by New York's Columbia-Presbyterian Medical Center. The kit comes in two models—male and female.

Apex Medical Supply has a new style unbreakable oral syringe for accurate delivery of oral medicines, especially for children and also useful for adults. The

syringe resembles a hypodermic syringe except that its tip cannot accept a Luer needle. Teaspoons vary in capacity from 2.5 to 9 cc; the syringe is accurate. The syringe is calibrated in cubic centimeters and in standard teaspoonsful.

Berkeley Bio-Engineering has a new system for prevention of deep vein thrombosis. Called Berkeley-Flowtron™, the system consists of a pair of inflatable leggings attached to a small portable air compressor. The leggings are alternately inflated and deflated to simulate normal pumping action of muscles during ambulation.

D. C. Heath has published "Better Homes for the Old," a study of the adequacy and hospitality of nursing homes in general (better than the popular conception). The circumstances of admission to nursing homes and the various plans for financing nursing home care are discussed. 176 pages—\$15.00.

Technical Resources, Inc. announces a highly reliable and rugged electronic blood pressure monitor designed for desk top use. It is easily portable. It features a large, easily read dial with a red LED light which flashes synchronously with pulse and indicates both systolic and diastolic pressures.

VARTA Batteries, Inc. announces the VARTA 20 DK Button Cell, a new and improved rechargeable nickel-cadmium hearing aid battery. It will last 16 hours on a single charge and may be recharged more than 500 times. The customer buys two cells and a charger. The VARTA system will pay for itself in less than three months.

The Prentke Romich Company of Shreve, Ohio, has been appointed the importer and distributor of an appliance, made in Holland, which enables victims of cerebral palsy, strokes and aphasia who cannot speak or write manually, to communicate by pressing keys on a keyboard. "Elkomi 2" is about the size of a standard pocket calculator. The screen holds nine characters at a time. As words build up, one letter drops off the screen at a time, much the same as an illuminated news display.

The Beecher Corporation has a new extracting device for use thru endoscopes or thru incisions. A manual manipulator has a flexible outer dilator which dilates the passage and the site of the foreign body. Vacuum is applied when the expanded sleeve is in contact with the foreign body. The inner sleeve is then retracted and when it is deflated the object is drawn into the sleeve. The sleeve protects the passage walls during withdrawal.

News of what is new in the medical supply industry is camposed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

What's New in Books?

Harper and Row just released a new book "Stroight Talk About Your Health Care" by Mack Lipkin, M.D. How to choose a doctor, what to expect of him, when to end your relationship with him. Dr. Lipkin has been in private practice for 40 years. The book answers questions most frequently asked by patients. \$8.95.

* * *

Lexington Books has just released a comprehensive "Dictionary of Abbreviations in Medicine and the Health Sciences." It contains some 11,500 entries with more than 33,000 meanings, on 314 pages. Priced at \$23.00.

* * *

Doubleday has released "Healthy Pregnancy The Yogo Way." The author is Judi Thompson, qualified for such writing by being a teacher of yoga and the mother of four. The book includes instructions on yoga breathing and exercise technics adopted to suit the particular needs of expectant and new mothers. 160 pages—\$3.95.

* * *

Elsevier North-Holland has published a book, "Power and Illness: The Political Sociology of Health and Medical Care." The author is Elliott A. Krouse, Ph.D., a Boston University sociologist. His theme is that unless medical care becomes less expensive, physicians will lose more and more control of medicine. Large corporations, says the author, will pressure the government to pass cost-cutting legislation, and/or will set up their own health care systems. Item: General Motors pays more for health insurance for their employees than they do for raw steel.

* * *

Heath and Company is publishing a book with the general theme of "Can the community hospital maintain

its sense of direction in the face of ever-increasing outside regulation?" Written by Dr. Kathleen M. Popko, a member of the Sisters of Providence who is associated with Brandeis University and Mercy Hospital in Springfield, Mass., the book is titled "Regulatory Controls: Implications for the Community Hospital." 192 pages—\$15.50.

* * *

D. C. Heath Company has released a new book "Toward a National Health Care Policy," written by Kenneth M. Friedman of Purdue and Stuart H. Rakoff of the United Mine Workers. It is concerned with control of costs. It also discusses supply of physicians, distribution of physicians, specialism, generic labeling of drugs and end-stage renal dialysis. 288 pages—\$18.00.

* * *

Charles Press Publishers has released "Guidelines for Chronic Care: A Team Approach," by Michael R. Soper, M.D. It is a manual designed to prepare nurse practitioners for an expanding role in primary health care. It presents clinical guidelines for the evaluation, monitoring and shared management of the ambulatory adult patient. 240 pages—\$11.95.

* * *

Doubleday has released "Labor & Delivery: An Observer's Diary." The author, Constance A. Beon, is a qualified expert in childbirth methods with an M.S. in public health from Yale. The book "tells parents what they need to know in order to make intelligent decisions about the kind of labor and delivery they want."

* * *

Grune & Stratton announces "Psychiatric Emergencies," written for use in emergency rooms. More and more patients appear in emergency rooms for psychiatric reasons. The authors, Drs. Glick, Meyerson, Robbins and Talbott, are all members of the Emergency Psychiatric Committee of the American Psychiatric Association. Price \$16.00.

* * *

Doubleday announces a book which traces the history of the American medicine show from the Renaissance in Europe to the early 20th century in the U.S. It is lavishly illustrated. The author is Brooks McNamoro, professor of drama in the School of the Arts at New York University. Pages, 233—price, \$12.95.

* * *

Academic Press has released "Acute Drug Abuse Emergencies: A Treatment Manual." It is edited by Dr. Peter G. Bourne of the Drug Abuse Council. The book is recommended especially for physicians who treat drug abuse emergencies only occasionally but it is also of value to those who see such emergencies frequently. Price \$16.50.



FUTURE MEETINGS, SEMINARS, COURSES

Dermatology Course in Maine in August

A course in "Office Dermatology" designed for primary care physicians will be conducted Aug. 3 to 6 at Colby College, Waterville, Maine. It is sponsored by the American Academy of Dermatology and Colby College. Registration fee is \$150. Enrollment is limited to 150 registrants. Write Department of Continuing Medical Education, American Academy of Dermatology, 820 Davis St., Evanston, Ill. 60201.

Fiberoptic Bronchoscopy Workshop

"Fiberoptic Bronchoscopy Workshop" is scheduled for Sept. 16 and 17 at the University of Kentucky in Lexington. Registration fee is \$200. Attendance is limited. Call or write Frank R. Lemon, M.D., College of Medicine, Lexington 40506.

"Pediatric Pitfalls" Program Planned

The Fourth Annual Fall Symposium on "Pitfalls in Pediatric Diagnosis and Management," sponsored by the Indiana University School of Medicine and the James Whitcomb Riley Hospital for Children, will be held Oct. 5 and 6 at Stouffer's Indianapolis Inn.

The visiting faculty will include Dr. John Nelson, Dallas;

Dr. Raymond Amoury, Kansas City; Dr. Peter Kottmeier, Brooklyn, and Dr. Medad Schiller, Jerusalem, Israel. Members of the Indiana University School of Medicine pediatric and surgical faculty will also take part.

Topics include:

Complications of infectious disorders (respiratory, otitis, meningitis);

Orthopedic, dermatologic, hematologic, gastrointestinal and liver disorders;

Neonatal care, trauma, child abuse, x-ray interpretation, intestinal obstruction and other surgical conditions.

The course is approved for 13 hours of postgraduate credit in the AMA Physician's Recognition Award program.

For further information write or call Jay L. Grosfeld, M.D., or Morris Green, M.D., James Whitcomb Riley Hospital for Children, 1100 W. Michigan St., Indianapolis 46202.

Plan Pediatric Orthopedic Conference

A "Pediatric Orthopedic Conference" will be conducted by the University of Tennessee College of Medicine Oct. 20 to 22 at the Sheraton Hotel, Gatlinburg, Tenn. Full information may be obtained by writing Dr. Harvey L. Goodman, 1924 Alcoa Highway, Knoxville 37920.

OCTOBER						
SUN	MON	TUE	WED	THU	FRI	SAT
<small>SEPTEMBER</small> <small>S M T W T F S</small> <small>4 5 6 7 8 9 10</small> <small>11 12 13 14 15 16 17</small> <small>18 19 20 21 22 23 24</small> <small>25 26 27 28 29 30</small>	<small>NOVEMBER</small> <small>S M T W T F S</small> <small>1 2 3 4 5</small> <small>6 7 8 9 10 11 12</small> <small>13 14 15 16 17 18 19</small> <small>20 21 22 23 24 25 26</small> <small>27 28 29 30</small>			<small>LAST QUARTER</small> <small>5th</small> <small>NEW MOON</small> <small>12th</small>	<small>FIRST QUARTER</small> <small>19th</small> <small>FULL MOON</small> <small>26th</small>	1
2	3	4	5	6	7	8
9	10 <small>Columbus Day</small>	11	12 <small>Traditional Columbus Day</small>	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
ISMA 1977 ANNUAL MEETING Hyatt Regency Hotel • Indianapolis						
30	31	NINETEEN SEVENTY-SEVEN				



TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

Prior to commenting on the errors which are on the new United States Gift Tax Return (Form 709, Revised February 1977), I want to make two concluding comments concerning the availability of the gift tax marital deduction.

First, the new law did not change any of the general tests which must be met in order for a donor to be *entitled* to a gift tax marital deduction. For example, a donor will still be *denied* a gift tax marital deduction for gifts (to the donor's spouse) for non-deductible terminable interests. Second, only one \$100,000 marital deduction base is available per donor. That is, a donor may not obtain a second \$100,000 base by obtaining a new spouse.

Now, as to the errors on the new gift tax form, they occur because of the form's presentation of the computation of the gift tax marital deduction. Specifically, the form is not correct in its presentation of the computation of the gift tax marital deduction for the purpose of computing the marital deduction for a donor who makes gifts in excess of \$200,000. That is, in certain cases the form does not allow a donor to obtain the 50% marital deduction (for gifts in excess of \$200,000) until the donor has, for all practical purposes, *taken* a marital de-

duction up to \$200,000. However, section 2523 is quite clear that a donor is entitled to the 50% marital deduction once the donor has taken a marital deduction of \$100,000 and has been taxed on the second \$100,000 of gifts. That is, section 2523 allows a donor to utilize the 50% marital deduction after the donor *has made* gifts in excess of \$200,000—even though the donor took a marital deduction of only \$100,000 on such gifts.

The problem occurs on line (h) (6) of page 2 of the new form. This is the line on which the Internal Revenue Service is attempting to determine the proper amount of the donor's gifts which qualify for the 50% marital deduction. That is, the purpose of line (h) (6) is to determine the amount of the donor's gifts which exceed \$200,000. To determine this excess, the *form* requires the donor to compute this excess by adding together the total value of the gifts of the particular quarter involved, line (h) (2) of page 2 of the form, to the total of the marital deductions which were *allowed* to the donor for prior quarters beginning after Dec. 31, 1976—namely, to the amount which appears on line (h) (4) of page 2 of the form. Obviously, then, in certain cases the Internal Revenue Service is forcing a donor to exceed the \$200,000 limitation by a combination of the present quarter's gifts and the marital deductions of prior quarters. However, as I stated in my May, 1977 article, section 2523 allows a donor to reach the \$200,000 mark by taking into account the second \$100,000 of gifts which were *taxable* to the donor, that is, the \$100,000 of gifts for which *no* marital deduction was allowed or allowable.

My first discussion with the drafters of the form did not result in immediate agreement by them. However, upon reflection, they now agree with my interpretation as to the present form, and I assume that a new form will be prepared and distributed shortly. Until then, do-

nors and their lawyers should be aware of the problem, and if a proper form is not issued, then a proper supplementary schedule should be prepared and submitted with the present form in situations in which the form would result in an erroneous computation of the gift tax marital deduction.

Now, allow me to shift my comments to the application of the gift tax rates and the gift tax credits. And, as a prelude, you should step out of the forest and examine, once more, the computation of the base (taxable gifts) upon which the new gift tax rates apply.

Total gifts	\$ x
Less exclusions	x
	—
Gross gifts	\$ x
Less:	
Charitable contributions	\$ x
Marital deductions	x
	—
Total deductions	\$ x
	—
Taxable gifts	\$ x
	—

Now, as to the application of the gift tax rates, there are a few gentle surprises. First, the former rate schedules (one for gift taxes and one for estate taxes) are repealed for taxable gifts after Dec. 31, 1976. These two rate schedules have been replaced by a "unified rate schedule," which appears in section 2001. The new schedule is "unified," because there is just *one* schedule of rates, for both gift and estate taxation.

The second significant aspect about the new rate schedule is that it is quite *high* in comparison with the former rate schedule. At the lower end, the *former* schedule is 2¼% on taxable gifts up to \$5,000, and 5¼% on taxable gifts up to \$18,000. However, the *new* schedule, at the lower end, is 18% on taxable gifts up to \$10,000. And, at the upper end, the *former* schedule goes as high as 57¾% on taxable gifts over \$10 million. However, the *new* schedule is fixed at 70% on

taxable gifts over \$5 million. I think that the easiest way for you to put these new rates in perspective is to identify them with the present income tax rates. That is, at the low point the new gift tax rates (at 18%) are four points higher than the lowest income tax rates. And, at the highest point both the gift tax rates and the income tax rates are fixed at 70%.

The third significant aspect about the new unified rate schedule is the manner in which the rates are applied. First, the gift tax rates are applied to the total lifetime taxable gifts through the particular quarter involved—including gifts made prior to Dec. 31, 1976. The inclusion of the pre-Jan. 1, 1977, gifts has the undesirable effect (from the donor's viewpoint) of pushing the post-Dec. 31, 1976, gifts (including the gifts of the particular quarter involved) into higher gift tax brackets. Second, the new gift tax rates are applied to the total of the taxable gifts which the donor has made (prior to, on and after Dec. 31, 1976) up to the calendar quarter involved. Then, this second gift tax is subtracted from the first gift tax, and the result is the gift tax which is payable on the taxable gifts of the quarter involved.

In theory, this second step is to subtract from the first tax, the amount of tax which would have been payable on the taxable gifts up to the quarter involved. However, in this second computation, the donor does not subtract the gift taxes which were actually paid on prior gifts. That is, even for gifts which were made prior to Jan. 1, 1977, and on which lower gift taxes were paid because of the lower former gift tax rates, the donor may use the new gift tax rates to compute the gift taxes which are subtracted from the first gift tax computation.

Note—again—in this two-step gift tax computation, the donor does involve taxable gifts from years prior to Jan. 1, 1977. I repeat this be-

cause I think that one of the most difficult aspects of learning the new law is remembering when to involve transactions of years prior to Jan. 1, 1977, and remembering when not to involve transactions in such years. So, let me restate two points which I have already made. In the case of the *gift tax marital deduction*, the donor only considers taxable gifts which are made after Dec. 31, 1976. Further, in the case of the application of the *gift tax rates*, the donor must consider taxable gifts made through Dec. 31, 1976—as well as those made thereafter.

After the donor has computed the gift tax payable for the quarter involved, the donor is entitled, under section 2010(a)-(b), to subtract another credit—the “unified credit”—against the gift tax already computed. There were no gift tax credits under the former gift tax law — except for the credit for the gift tax on all gifts up to the quarter involved, which was offset against the gift tax on all gifts through the quarter involved. The new unified credit increases from \$6,000 for gifts made during the period of Jan. 1, 1977, through June 30, 1977, to \$30,000 for gifts made during the period of July 1, 1977, through Dec. 31, 1977, until, after other increases, the credit reaches \$47,000 for gifts made during 1981 and thereafter.

The main purpose of the new unified credit is to treat persons who make small gifts as favorably as persons who make large gifts. That is, under the former law, if a donor made a gift when the potential effective gift tax rates (on the gift) were, for example, 30%, then the former \$30,000 exemption could have saved the donor \$9,000 of gift taxes. On the other hand, if another donor was in the effective gift tax bracket of 40%, then the former \$30,000 exemption would have saved the latter donor \$12,000 of gift taxes. However, the new credits save each donor the same amount of money.

There are two possible reductions of this new unified credit. First, section 2010(c) states that the allowable credit shall be reduced by 20% of any portion of the former \$30,000 exemption which the donor used for gifts made after Sept. 8, 1976, and prior to Jan. 1, 1977. That is, if a donor used any part of the donor's \$30,000 lifetime exemption when the donor made gifts during the period of Sept. 9, 1976, through Dec. 31, 1976, then the donor will lose some of the unified gift tax credit which is available after Dec. 31, 1976. Thus, for each year after Dec. 31, 1976, a donor who so used a portion of the donor's exemption must reduce the donor's unified credit for each year by the applicable 20%. Also, as I will point out in a later article, the donor will lose the same amount of the donor's unified estate tax credit by such use of the donor's gift tax personal exemption during that period. If a donor used the donor's exemption prior to Sept. 9, 1976, then the donor will not lose any of the donor's new unified gift tax credit. The second reduction in the unified credit is the reduction caused by any uses of the unified credit for years which are prior to the particular quarter involved.

Thus, for individuals who begin making taxable gifts after Dec. 31, 1976, there are two gift tax credits. First, there is a credit for the amount of gift tax which would have been payable on the sum of all taxable gifts which have been made during the donor's lifetime up to the current quarter. Second, there is a credit, which is fixed by law at certain amounts for each year. As to this latter credit, it increases each year until 1981, at which time it is fixed at \$47,000. Further, while this latter credit is increasing each year, it will also be reduced each year, by two amounts, namely, by any prior uses of this credit for a prior quarter, and by 20% of the amount of any use of the \$30,000 personal exemption during the period of Dec. 9, 1976, through Dec. 31,

Continued

Deaths

Paul A. Batties, M.D.

Dr. Paul Andrew Batties, Indianapolis, died April 17 in Methodist Hospital. He was 63.

Upon his graduation from the University of Chicago School of Medicine in 1937, Dr. Batties received a Rosenwald Fellowship for further study in surgery. He was licensed to practice in Indiana in 1941.

A member of the Aesculapian Medical Society, Dr. Batties recently completed a term as chairman of the family practice section of Winona Memorial Hospital. He was a member of the Marion County Medical Society and the American Medical Association.

John W. Hendricks, M.D.

Dr. John Wesley Hendricks, Indianapolis urologist, was killed in an auto accident May 28. He was 74.

A graduate of the Indiana University School of Medicine, Dr. Hendricks interned at Indianapolis General Hospital and did a residency at Santa Fe Hospital, Los Angeles. He was a charter member of the Community Hospital staff and had served as president of the medical staff at St. Francis Hospital Center.

He taught for many years at the Indiana University School of Medicine.

Dr. Hendricks was a member of the American Urological Association and its North Central division and was certified by the American Board of Urology. A former Marion County deputy coroner, he was also a former president of the Marion County Medical Association and was a member of the American Medical Association.

A Senior Member of the Indiana State Medical Association, Dr. Hendricks had served as a delegate and on the Legislation Commission.

William A. Kemp, M.D.

Dr. William A. Kemp, 69, Bourbon, died April 7 at home.

Dr. Kemp was medical director of the Five-County Mental Health Clinic at Warsaw from 1968 to 1975, and formerly had a limited practice at Bourbon. He practiced at Connersville from 1936 through 1963, when he moved to Bourbon.

A graduate of the Indiana University School of Medicine in 1933, Dr. Kemp was also an intern and resident at the medical center. He served with the Air Force in World War II.

He was a member of the Marshall County Medical Society.

William B. Matthew, M.D.

Dr. William Burleigh Matthew, Indianapolis ophthalmologist, died May 25 in Methodist Hospital. He was 69.

He received his medical degree in 1933 from Indiana University Medical School and interned at St. Elizabeth Hospital, Lafayette, following which he served as a medical officer in the Civilian Conservation Corps. He was a resident in ophthalmology at Indianapolis General Hospital in 1936 and 1937, opening his office in Indianapolis in 1937. During World War II Dr. Matthew served five years with the Army, one year of which was in France.

A visit to a church-supported mission

in India in 1960 interested Dr. and Mrs. Matthew in providing better medical care for the people of the area, and they embarked on a fund-raising and medical equipment project which aided in the construction of a 25-bed hospital in the Udrir area. They also were instrumental in the building of a leprosy treatment center and succeeded in sending tons of medical materials and supplies to India as well as shipping 185,000 pairs of eyeglasses. During two additional trips to India Dr. Matthew performed operations daily at the missionary eye clinic and at eye surgery camps.

Dr. Matthew was a member of the Marion County Medical Association, the American Medical Association, the International Society of Surgeons and the World Medical Society.

Loren F. Schmidt, M.D.

Dr. Loren Fredrick Schmidt, 67, Indianapolis surgeon, died April 22.

A graduate of Indiana University School of Medicine with the Class of 1941, Dr. Schmidt interned at St. Vincent Hospital and was a resident in surgery at Methodist Hospital. He practiced in Indianapolis until he retired from surgery in 1973, following which he served as a member of the Medical Review Board of the Department of Public Welfare.

During World War II Dr. Schmidt served with the United States Navy and was on active duty in the South Pacific for 17 months.

Dr. Schmidt was a member of the American Medical Association and the Marion County Medical Society.

TAX TIPS

Continued

1976. Of course, both credits are non-refundable credits—under section 2010(d).

One final point concerning tax reform in general. On April 28, 1977, Representative Ullman intro-

duced a 94-page bill (H.R. 6715) for the purpose of correcting the "technical and clerical" mistakes in the Tax Reform Act of 1976. As you would guess, many of the changes are significant substantive

changes and many of these changes affect gift and estate taxation. If the bill passes, and I would think that it would pass with ease, I'll incorporate the changes in each appropriate article. ◀

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New Double-Blind Study ANDROID-25 vs. Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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THE SECOND Purdue Cardiac Defibrillation Conference will be held September 19-21, 1977 at West Lafayette, Indiana. The program includes 23 speakers, all of whom are active in clinical application of defibrillation or in basic research concerning defibrillation.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



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MEDICAL

MUSEUM NOTES



Theophilus Parvin, M.D., has the distinction (according to Kemper) of being the first physician in Indiana to write a medical textbook. He was also a pioneer in medical journalism—starting the *Western Journal of Medicine* in 1866. Four years later this journal was succeeded by the *Indiana Journal of Medicine*, which was renamed the *Indiana Medical Journal* in 1882. It continued under that name until 1908, when the present *Journal of the Indiana State Medical Association* commenced.

Born at Buenos Aires, Argentina, Jan. 9, 1829, of missionary parents, Theophilus Parvin was reared in New Jersey. In 1847 he graduated from Indiana University, then taught for three years in New Jersey. In 1852 he received his medical degree from the University of Pennsylvania, and, in 1853 (age 24), set up practice at Indianapolis, later marrying Rachel Butler of Hanover.

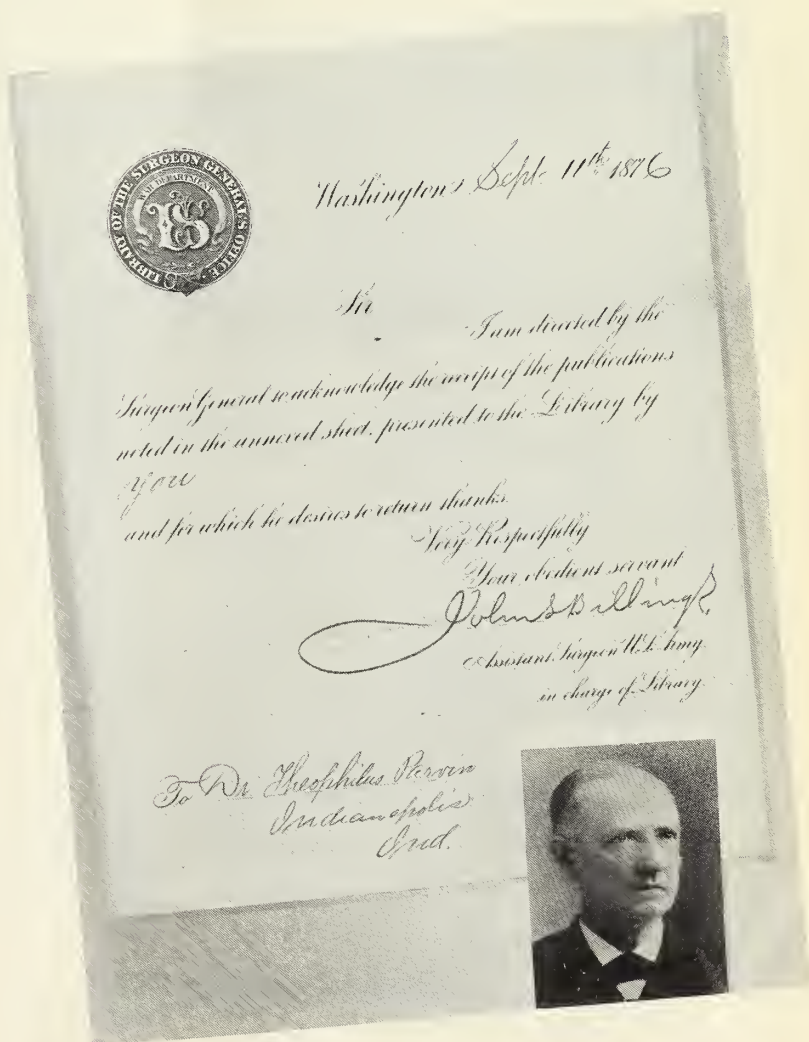
Dr. Parvin served as president of the Indiana State Medical Society in 1862. The Civil War was then in progress. When General Morgan crossed the Ohio River into Indiana on his notorious raid, the entire state felt the threat. Governor Morton issued an emergency call for volunteers and 13 regiments were raised in two days, with Dr. Parvin assigned as surgeon of the 107th Regiment. His service, however, like the emergency, was of short duration.

In 1864 he was appointed to the chair of *Materia Medica and Thera-*

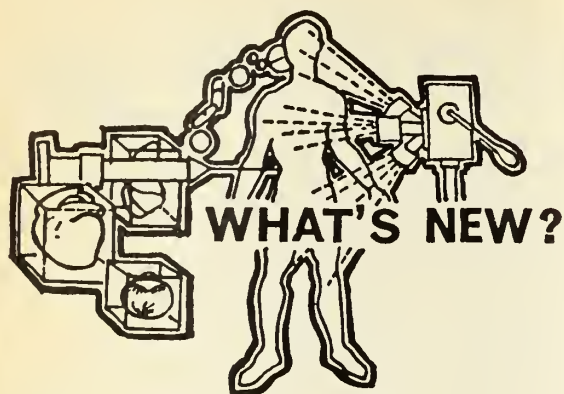
peutics in the Medical College of Ohio, and later to the chair of Medical and Surgical Diseases of Women. He also taught at the University of Louisville, and later, when the College of Physicians and Surgeons was organized in 1872 in Indianapolis, he was appointed a member of that faculty, continuing on with the Medical College of Indiana when the two local schools united under that name in 1879. In 1883 he was appointed to the chair of Obstetrics and Diseases of Women and Children in the Jefferson Medical College at Philadelphia, where he remained until his death on Jan. 29, 1898.

Dr. Parvin also had an interest in medical history. On Sept. 11, 1876, he presented three volumes of Rush's lectures in manuscript form to the library of the Surgeon General's office. His acknowledgment for this was signed by the Assistant Surgeon, U.S. Army, in charge of library, John S. Billings. This receipt was recently given to the Medical History Museum by Mr. Rudolf K. Haerle of Indianapolis.

The Museum also has a copy of Dr. Parvin's book, *The Science and Art of Obstetrics*, 3rd edition, published in 1895. The first edition was written while Dr. Parvin lived in Indianapolis.



ACKNOWLEDGMENT by John S. Billings, Assistant Surgeon, U.S. Army, of gift by Dr. Theophilus Parvin (inset) to the library of the Surgeon General's office of three volumes of Benjamin Rush's lectures in manuscript form.



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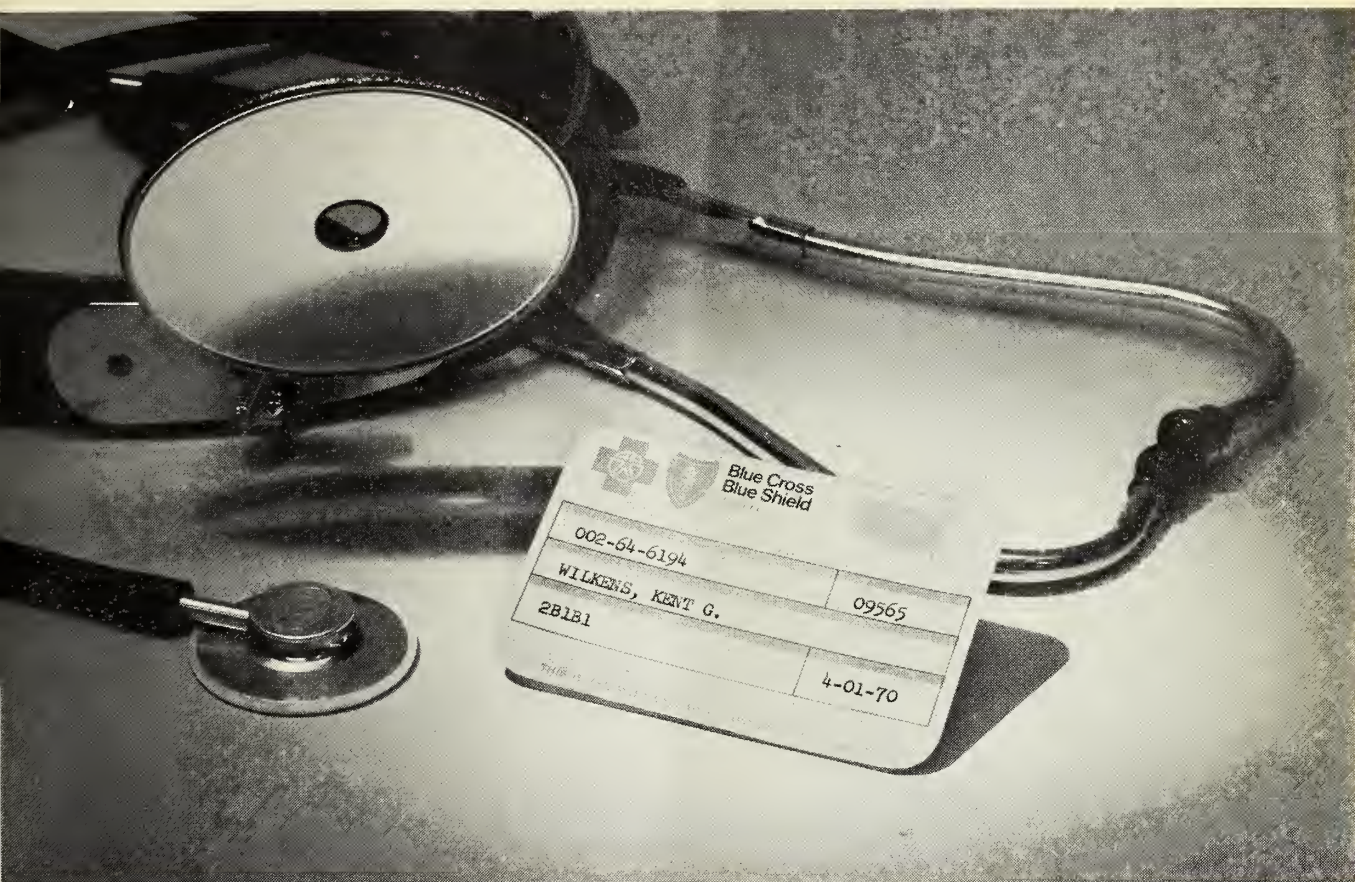
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Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

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When **impotence** due to androgenic deficiency is driving them apart



Android[®]-5 Buccal
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Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 vs. Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

DETERMINED TO CURB RISING HOSPITAL COSTS, the Congress has opened hearings on legislation proposed by Sen. Herman Talmadge (D-Ga.) that would institute a prospective reimbursement plan for the nation's hospitals. The Talmadge bill is considered a rival of the Administration's proposal to place a 9% "cap" on hospital revenues.

The Administration has told the Senate Finance Subcommittee on Health, headed by Talmadge, that it likes some provisions of the Talmadge bill but that it is imperative that the controversial "cap" proposal be enacted, perhaps with features of the Talmadge bill included.

Most health provider groups, including the American Medical Association, found the Talmadge plan much more palatable than the Administration's bill, though they took issue with some of the Talmadge provisions.

Raymond T. Holden, M.D., chairman of the AMA Board of Trustees, told the Subcommittee "we commend the sponsors of this legislation for its broad coverage of a variety of issues in the Medicare and Medicaid programs." While there are some provisions the AMA does not support, "there are many others which we believe would be beneficial and for which we urge your favorable consideration," Dr. Holden testified.

The Administration's arbitrary ceiling or "cap" on total hospital revenues "lacks appropriate flexibility, provides disincentives for efficiency and, in fact, would reward inefficiency," said Dr. Holden. "Most importantly, that proposal would impact unfavorably most directly upon the continued provision of quality care."

The Talmadge provisions "attempt to meet the hospital cost problem in a more positive and equitable manner than that of the Administration," Dr. Holden said. "However, notwithstanding our belief that the Talmadge bill is a more realistic program, we do believe that adoption of the program in the manner presently proposed could have uncertain and perhaps even undesirable effects."

"Risks of any single new program imposed nationally are not warranted at this time especially when there are other potential alternatives which merit similar consideration," Dr. Holden said. "Experiments with various reimbursement methods have not been fully implemented and evaluated. We would recommend that the cost containment incentive program of this bill be the subject of experiment and demonstration in a limited geographic area before being considered for nationwide application. We feel that all interested parties would benefit from such a procedure."

The AMA witness termed "beneficial" another provision encouraging the voluntary elimination of underutilized beds and the closing of facilities or parts thereof.

Dr. Holden said "we also recognize the problem of increasing health costs and are seeking solutions." He noted the AMA's establishment of a National Commission on the Costs

of Medical Care, which will examine the causes of medical care cost inflation and recommend policies that will contribute to containment of medical expenditures. The final report will be issued in January 1978.

Also appearing for the AMA was Edgar T. Beddingfield, Jr., M.D., chairman of the AMA Council on Legislation. Dr. Beddingfield said several provisions of the bill on physician reimbursement "could have a detrimental effect on the availability and quality of care." The proposed creation of a special class of practitioners, designated as "participating physicians," though somewhat modified this year, would still cover those who agreed to accept all Medicare reimbursement for their services on the basis of assignments. Inducements such as simplified claims procedures would be offered to encourage physicians to become "participating physicians."

Dr. Beddingfield said the proposal "does not reach the issue of why assignments are not widely accepted. The major deterrent to assignments is the insufficient reimbursement rate under Medicare and this proposal does not correct this problem."

Califano said the Talmadge reimbursement plan suffers from lack of available data and methodology to put it into effect. "Further, it only covers about 35-40% (Medicare-Medicaid) of present hospital costs, and will not, in our judgment, effectively control costs in the immediate future," said Califano.

The Talmadge plan could cost up to \$50 million more next fiscal year, in contrast with the estimated national savings of \$1.9 billion for the Administration's Hospital Cost Containment Act, according to the cabinet officer.

PHYSICIAN FEES EVENTUALLY MAY NEED COST CONTROLS, HEW Secretary Califano has told Congress.

"Eventually the health care system will have to deal with physician fees," the secretary told the Senate Finance Subcommittee on Health.


Califano said he and President Carter considered controls on physician fees as well as hospitals earlier this year but rejected them "because we just don't know yet how to deal with that problem."

Califano also opposed a provision in the Medicare-Medicaid reform bill by Subcommittee Chairman Talmadge which would lift the legal requirement for publishing the names and income of physicians and other Medicare providers. The HEW official said "sunshine is the greatest disinfectant," referring to the so-called Sunshine, or Freedom of Information Law.

Talmadge said he would withdraw the provision "if you (Califano) guarantee the accuracy" of future reports.

Califano noted that he apologized to the AMA for the high rate of error in this year's report and that a revised and corrected list would be published.

Continued on page 637



Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

Most Widely Prescribed—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

Relief of Nausea and Vomiting—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.

Dosage for Vertigo*—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg/kg/day in rabbits and 10 mg/kg/day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.


Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

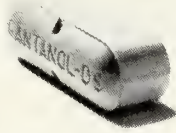
Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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Antivert[®]/25 
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Gantanol[®] DS
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**double-strength dosage form
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ew Gantanol® DS (sulfamethoxazole) tabs offer even greater convenience and economy for your patients with acute, unobstructed cystitis due to susceptible strains of *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus*, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*... The same amount of medication, the same efficacy, with only *half* the number of tablets per day. Simplified dosage regimen encourages patient compliance: 2 tablets (1 Gm each) B.I.D.—then 1 tablet B.I.D. for 10 to 14 days. Clinical efficacy so basic you can start cystitis therapy even before culture results are available.

- In a clinical study of 406 patients on Gantanol (sulfamethoxazole) B.I.D., close to 9 out of 10 patients achieved negative urine cultures. While Gantanol tablets were used in this study, one Gantanol DS tablet has been proved bioequivalent to two Gantanol tablets.*

Gantanol is contraindicated during pregnancy, during the nursing period, and in infants under 2 months. During therapy, maintain adequate fluid intake, perform frequent CBC's and urinalyses with careful microscopic examination.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

and economy

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus*, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*), in the absence of obstructive uropathy or foreign bodies. Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than 2 months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A α -hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under 2 years of age with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); allergic reactions (erythema multiforme, skin rashes, epidermal necrolysis, urticaria, serum sickness,

pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis). *Usual adult dosage:* 2 Gm (2 DS tabs or 4 tabs or 4 teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially; then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: DS (double strength) tablets, 1 Gm sulfamethoxazole; Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

Basic therapy with convenience and economy:

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Basic therapy with even more convenience and economy:

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MAKES SENSE

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplemental potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions:

Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions;

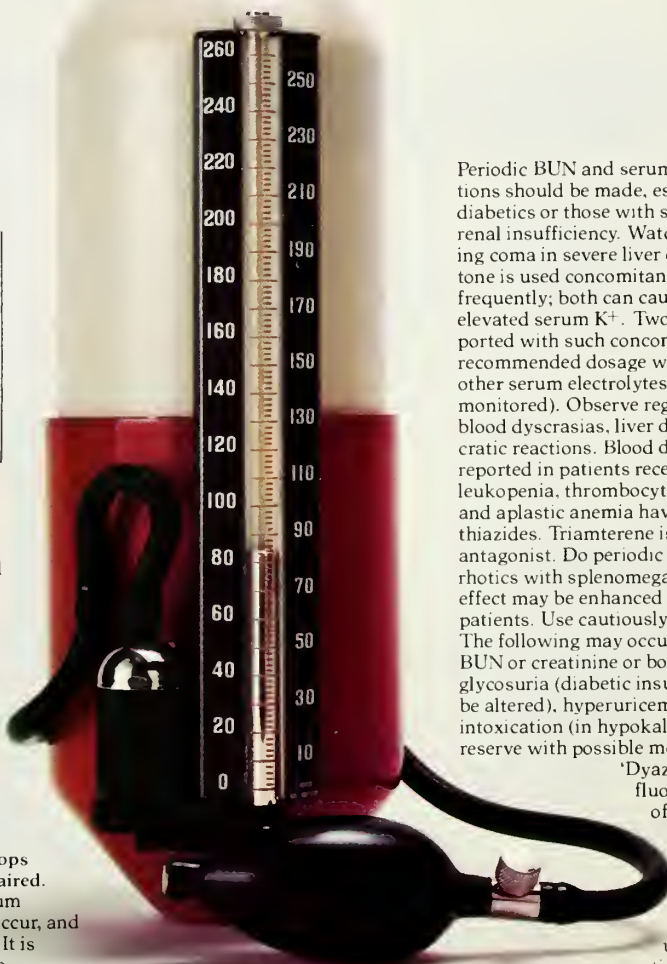
nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

**FOR LONG-TERM CONTROL
OF HYPERTENSION*
SERUM K^+ AND BUN SHOULD
BE CHECKED PERIODICALLY.
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MONTH IN WASHINGTON

Continued

THE MEDICARE-MEDICAID ANTI-FRAUD AND ABUSE legislation is winding through a complicated pathway in two powerful House committees—Ways and Means and Commerce. Both committees have jurisdiction over the bill before it reaches the floor.

The Ways and Means Committee is ready to report a bill and the full Commerce Committee is preparing to act also. One major difference between the committees, not yet resolved, is the degree of access federal investigators will have to patient records for the purposes of fraud and abuse investigations and epidemiological surveys.

IN AN EFFORT TO BOOST THE NEW office of Inspector General, HEW Secretary Califano has charged that fraud and abuse by physicians and pharmacists in the Medicaid program "is a serious problem."

He said "this conclusion emerges from an innovative, systematic two-month-old investigative effort being conducted by HEW's new Inspector General, working in cooperation with the new Health Care Financing Administration."

Califano said that through computers programmed to flag suspicious cases in state Medicaid files, 172 cases have been identified involving "what appear to be the worst physician and pharmacist offenders against the Medicaid system." He did not release any names.

The new computerized system has allowed HEW to screen 252 million transactions over a 12-month period involving 231,000 physicians (108 million claims) and 44,000 pharmacies (144 million claims).

The goal of the new investigation—which is called "Project Integrity"—is to identify 500 cases of apparently flagrant physician and pharmacist fraud or abuse in Medicaid.

Physicians and pharmacies were chosen as initial targets of the new computer investigation "because computer programs were already available for application of the innovative techniques."

RENEWED PROSPECTS OF ADMINISTRATION ACTIVITY next year on national health insurance has spurred congressional interest in the issue. At last count 22 lawmakers from both parties have co-sponsored the AMA's comprehensive health insurance plan for all, bringing to 30 the number of Senators and Representatives who have backed the proposal officially.

Early next year, the Carter Administration will submit its own NHI plan. President Carter and HEW Secretary Califano have said they will make a determined effort to secure Congressional enactment.

"THE FEDERAL TRADE COMMISSION is not a health or medical agency," FTC Chairman Michael Pertschuk has told a conference on competition in health care.

The business of the FTC is business, and we recognize, along with most Americans, that the delivery of health care is business, an industry of vast proportions and vital effect. Health care has become our business.

Mr. Pertschuk opened a two-day conference, sponsored by the FTC which rarely holds such events, with a reference to the AMA.

"The FTC is now in the process of receiving documents subpoenaed from the AMA, and certain state and local medical societies. Our intention is to learn how self-regulation—professional control over voluntary and state agencies—really works. There is reasonable doubt that the medical profession, by itself or through friendly state governments, is completely open to innovation, competition, quality control or consumer choice."



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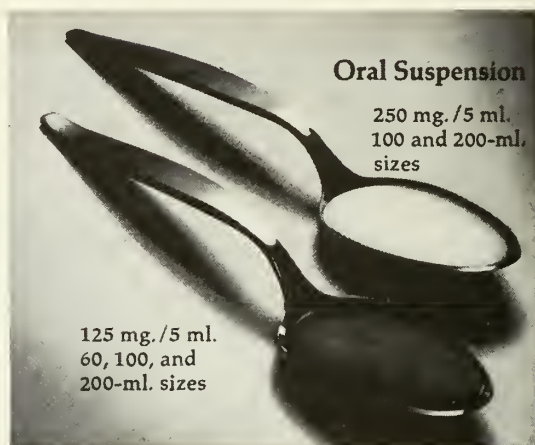
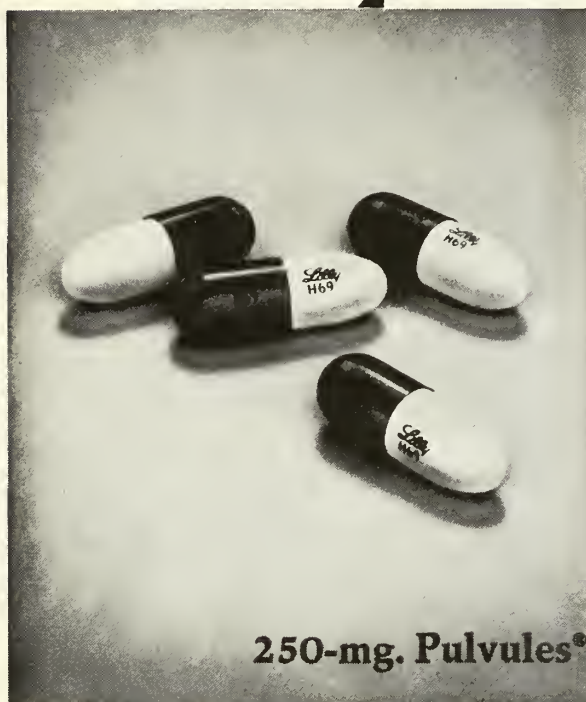
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Adult Exstrophy of the Bladder with Adenocarcinoma

LAWRENCE E. ALLEN, M.D.

Anderson

SINCE the first described case of malignant degeneration in an exstrophied bladder in 1895¹ some 56 cases of such were assembled and reported by O'Kane et al. in 1968.² Two additional cases were also described by N. Chelloul et collaborateurs in 1967.³

The exact incidence of malignancy occurring in bladder exstrophy can only be inferred from such studies as cited by the Mayo Clinic, in which they were able to find seven cases of adenocarcinoma, or 4%, in 170 cases of exstrophy treated from 1909 to 1949.⁴ McIntosh and Worley noted two cases of adenocarcinoma in a series of 25 patients with exstrophy.⁵ The potential for malignancy developing in exstrophy of the bladder is an intangible figure, since attempts at functional closure or diversion procedures are more universally performed now in the first few years of life. In the untreated group of exstrophy patients the potential incidence of malignancy is equally difficult to determine, because only one third have been found to survive into adulthood and only 10% live to maturity.⁶

Of the 58 cases of bladder exstrophy complicated by malignant degeneration that have been recorded in the literature,^{2,3} 49 cases were classified as adenocarcinoma. In the remaining cases two were reported as squamous cell carcinoma

and one was found to have a histological pattern of transitional cell carcinoma. Males have predominated 2 to 1. Age distribution illustrates the peak incidence of carcinoma in the fourth, fifth and sixth decades of life. The youngest patients thus far recorded were 21 years of age and the oldest 73 years.

The fact that continued exposure of the exstrophied bladder gives way to malignant degenerative changes is borne out by the observations of several authors. The experience of surgeons utilizing closure of the bladder as a therapeutic effort has, by comparison, been more favorable in regard to neoplasm. Herein, only a few, if any, cases have been found with malignant change occurring in an exstrophied bladder after functional closure.⁷ Continued follow-up, however, may be necessary to confirm this impression.

The development of malignancy, then, in the exstrophied bladder has been the experience of the untreated patient who has survived to at least 21 years of life. The occurrence rate of malignancy in such untreated patients becomes more pronounced in the fourth, fifth and sixth decades of life, as exemplified by the following case.

Case Report

M. J., a 50-year-old white female, was admitted for bladder biopsy after being seen by her at-

tending physician just prior to referral with complaints of bleeding and increased soreness of the exposed bladder. It is interesting to note that this was the first visit to a physician since age 14 when she was initially evaluated for surgery of the bladder and dismissed without treatment. Her only bladder care had consisted of daily olive oil application to the bladder. There had been no history of infective complication. Her only afflictions aside from exstrophy included mental retardation and arthritic manifestations involving her hips. The latter had required the use of a wheelchair for mobilization beyond walking around her home. She was reared by her parents who are presently in their seventies. They have one other offspring, a male, who is 44 years of age. He is normally developed mentally and physically although he suffered a severe myocardial infarction at age 42 from which he appears fully recovered.

On physical examination, the patient was well nourished and, although mentally retarded, was conversive and pleasant natured. The obvious congenital exstrophy of the bladder displayed ulcerative and fungating characteristics involving most of the exteriorized surface. The mucosa was quite inflamed and thickened, and bleeding was provoked by the slightest con-

tact. The vaginal introitus was small, approximating 1 cm, and the urethra was nonexistent. (Figure 1) Jets of clear urine periodically erupted from the edematous bladder surface.

Intravenous pyelograms displayed surprisingly little alteration in the architecture of the upper urinary tracts. (Figure 2) The patient's hemogram and blood urea nitrogen determinations were considered normal. She was afebrile on admission and the urine obtained from the catheterization of one ureter showed no growth on culture study.

Bladder biopsy performed on March 7, 1972, revealed adenocarcinoma with muscular invasion.

Subsequent treatment consisted of radical cystectomy and bilateral uretero-ileo-cutaneous anastomosis. At the time of surgery there was no evidence of lymphatic metastasis and the abdominal viscera were negative for metastatic disease. Repair of the abdominal wall was achieved in one stage as described by Scott and Carlton.⁸



FIGURE 1
Anterior view of patient's exstrophied bladder illustrating anomalous genitalia.

Gross examination of the excised bladder revealed a thick-walled structure measuring 7 cm in diameter and showing on its surface a fungating, friable lesion with granular, hyperemic and ulcerative changes.

Histologically, the mucosal surface was replaced by neoplastic tissue composed of cells arranged in a colonic, gland-like pattern extending into the underlying bundles of smooth muscle. (Figure 3) Scattered here and there were small islands of mucus-secreting glandular structures.

Discussion

The etiological consideration of malignant disease in bladder exstrophy has prompted studies of the histological changes occurring in these exposed bladders from birth through maturity. Culp⁹ learned that even if one assumes that such a bladder is histologically normal at birth, acquired abnormalities are manifest in the first few weeks of life. Sturdy¹⁰ noted that these acquired abnormalities became more pronounced the longer the exstrophied bladder was exposed to an external environment. The mucosal alteration ranged from transitional cell proliferation to squamous metaplasia and glandular for-

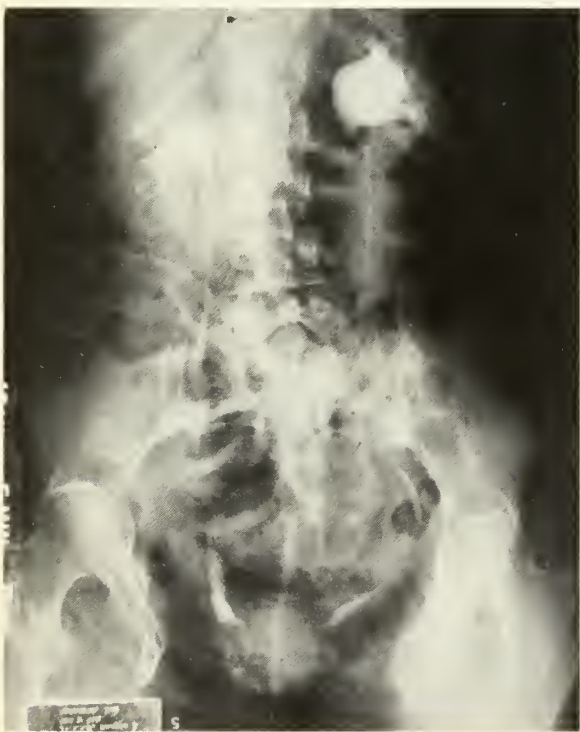


FIGURE 2
Preoperative excretory urogram showing fairly well preserved upper urinary tracts and wide separation of the pubic bones.

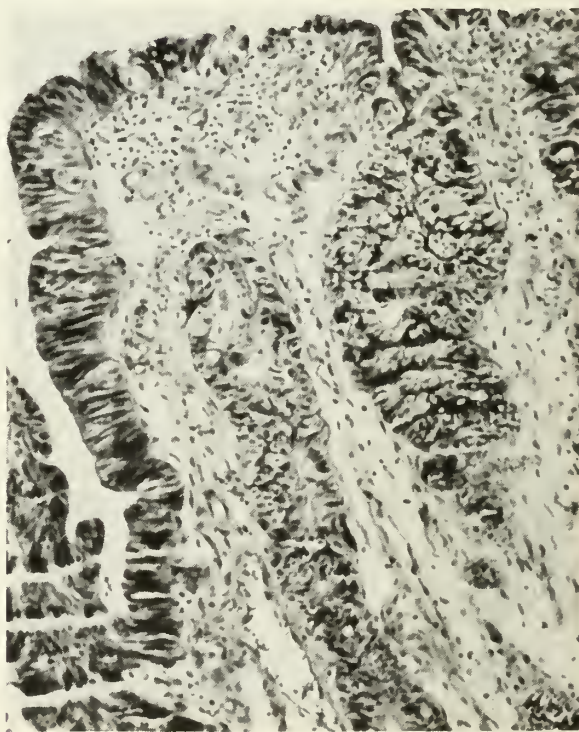


FIGURE 3
Adenocarcinoma in exstrophy of bladder, high power photomicrograph.

mation resembling, in the latter instance, the cellular pattern of large bowel mucosa.

The frequent occurrence of adenocarcinoma in cases of bladder exstrophy has been attributed to a process of metaplasia in which a protective mucus is produced. This supposition is supported by Mostofi,¹¹ whose studies of the potentialities of bladder epithelium illustrate that no mucus glands were found in the mucosa of normally developed bladders.

The predominance of adenocarcinoma over transitional cell and squamous cell carcinomatous varie-

ties in bladder exstrophy is certainly a reversal of the findings in the non-exstrophied bladder. In the report of Dean et al.¹² only 17 cases of adenocarcinoma were noted in a series of 1,400 bladder tumors.

The prognosis in exstrophy patients with malignant complication is relatively favorable in regard to metastatic disease. Only two cases of patients dying with metastatic disease have been reported.¹³ Local recurrences, however, have been reported in at least three instances.^{4,14,15} Thus, radical excision of the carcinomatous bladder is recommended in all cases.

Summary

An example of exstrophy of the bladder complicated by carcinoma has been presented.

A review of the literature discloses 58 such cases that have been previously published and analysis of the findings therein has been featured.

27 River Forest
Anderson 46011

A copy of the references pertaining to this paper may be obtained by writing to *The Journal*, 3935 N. Meridian St., Indianapolis 46208.

There's a Word for It

RICHARD J. NOVEROSKE, M.D.
Evansville

Auris Nerve

I think the nerve to the ear, the eighth cranial nerve, should be named the "auris nerve." "Auris" is short, two syllables long, and it's specific; it means "ear" in Latin.

Until about 20 years ago we were taught to name the eighth cranial nerve the "auditory nerve." It was a long word, "auditory"—it had four syllables, but it fitted nicely with that old Mnemonic, "On Old Olympus' Towering Top, A Finn And German Viewed A Hop." And we could remember that the eighth cranial nerve started with the letter "A."

But "auditory" means "to hear," and it was pointed out that the ear was more than an organ of hearing. The ear is also an organ of balance; so the nerve that supplies it was renamed "stato-acoustic nerve."

That gave us a six-syllable word, and clinicians started not using the name, instead, referred to it as the "eighth cranial nerve."

More anatomists came along and pointed out that the ear is not only an organ of static balance, but also of dynamic balance, in addition to being an organ of hearing. So the name for the nerve to the ear was changed again, and now we have "vestibulo-cochleare," an eight-syllable monster that virtually nobody uses clinically, for it's too long. It violates the rule of anatomic terminology that a term be as short as practicable.

Also, the term "vestibulo-cochleare nerve" misses the mark in describing what this nerve innervates and does. It not only innervates the vestibule and the cochlea, but also the semicircular canals that provide dynamic balance. "Vestibulo-coch-

leare nerve" is longer than "stato-acoustic nerve," and no more honest in defining what it does. To accurately describe the structures innervated one should say "vestibulo-canaliculo-cochleare nerve." But this term that includes the semicircular canals is so long, with 13 syllables, that it is obviously impractical.

Most people in medicine and the allied arts and sciences are aware that the ear is both an organ of hearing and balance. Why not build on this widespread knowledge of the function of the ear and simply name the nerve to the ear the "ear nerve" or the "auris nerve"?

A side advantage of "auris nerve" is that we can go back to using that old mnemonic for remembering the names of the 12 cranial nerves.

3901 Lincoln Ave.
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Benign Lytic Tumor of the Ilium

(Desmoplastic Fibroma)

— A Case Report

HAROLD E. STADLER, M.D.
HUGH L. WILLIAMS, M.D.

Indianapolis

THREE weeks prior to his hospital admission, J.D., the 15-year-old patient, had fallen while playing basketball. Pain developed in the left groin; however, his walking was not affected. Physical find-

ings were minimal and consisted of deep tenderness in the left groin and some restriction of abduction of the left hip.

The sedimentation rate was 3 mm per hour, and routine urinalysis, CBC, Chem XIV, and serology were normal. X-ray of the pelvis (Fig. 1A and 1B) was requested

From the Department of Orthopedic Surgery, Community Hospital, 1500 N. Ritter Ave., Indianapolis 46219.



FIGURE 2

Microscopic section of the tumor. The soft tissue nodules consist of uniform spindle cells arranged in a substance rich in collagen fibers. At the edge of the nodule the tissue is more loosely arranged. One section contains a cluster of plasma cells; other than this, there is no inflammatory infiltrate.

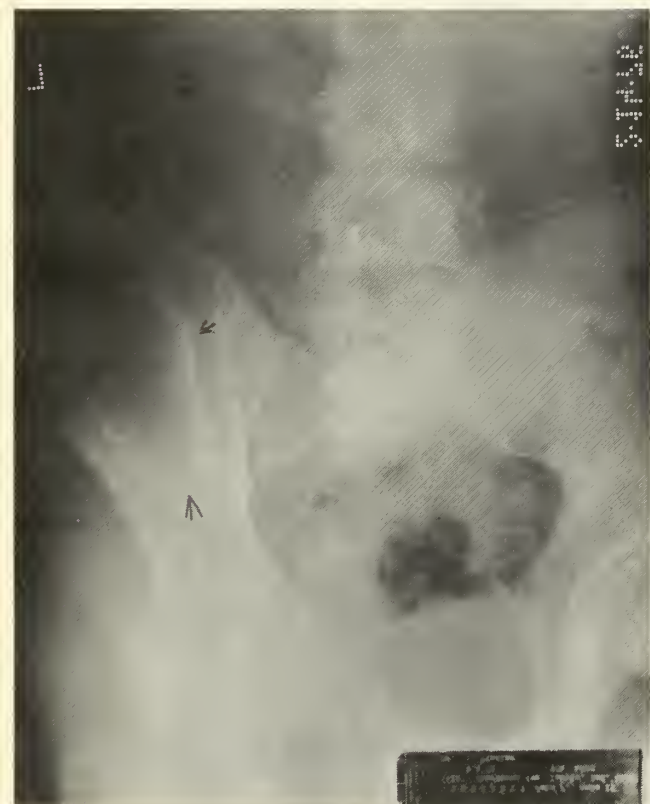


FIGURE 1A AND 1B

Radiograms of the pelvis showing the lytic lesion of the left iliac wing. The medial margin of the lesion is somewhat sclerotic and the

lateral border ill-defined. A minor degree of mottling is noted adjacent to the inferior margin of the lesion.

because of the persistent pain, and the findings led to the admission.

On 2-23-76, biopsy-curettage procedure was carried out. Routine cultures were reported to be negative. The patient was dismissed on 2-28-76 following an uncomplicated postoperative course.

Discussion

Rabhan and Rosai¹ reported 10 cases of desmoplastic fibroma in 1968. The tumor was found to involve the ilium in three of their cases and the presenting symptoms involved pain in the hip, groin or

lower abdominal region. These authors added 15 cases from the literature and found the average age of the patients to be 16.7 years. No metastatic phenomena were noted to appear but attention was called to the fact that a relationship appeared to exist between recurrence of the tumor and its cellularity.

It is of interest that Ferguson² in 1974 reviewed the literature with regard to central fibroma of the jaw. Twelve of 27 cases were of the desmoplastic type, thought to be locally aggressive and which could well be treated by excision rather

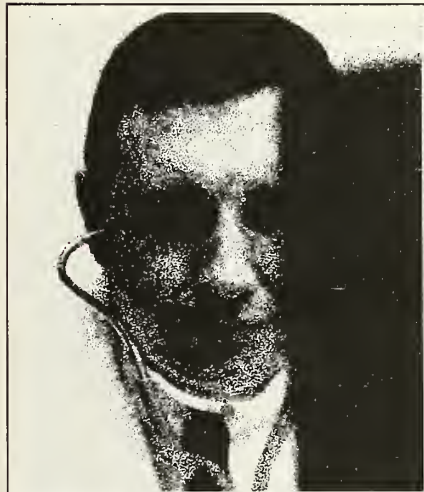
than enucleation, which was the indication suggested for the other fibromas. Pathological fracture was reported in the humerus, femur and jaw.

ACKNOWLEDGEMENT

The authors are indebted to Messrs. Donald Bernhard and Thomas Wagner for the photographic work.

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The Pulmonary Intensive Care Unit

LAWRENCE M. LAMPTON, M.D.
RICHARD E. BRASHEAR, M.D.

Indianapolis

CHRONIC obstructive lung disease has been increasing at a faster rate than other major health problems. Advances in the fields of neurology, infectious disease management, organ transplantation and cancer chemotherapy have dramatically improved patient survival and increased the number of patients with acute and chronic pulmonary problems. Therefore, a comprehensive pulmonary care program is required to provide the broad spectrum of care between the acute problems and the rehabilitative training of these patients.

Acute respiratory failure is a frequent occurrence in such a comprehensive pulmonary care program and, therefore, a pulmonary intensive care unit (PICU) is the major key in such a program. A better understanding of the mechanisms and pathophysiology of acute respiratory failure, the evolution of sophisticated monitoring equipment, improved ventilators and the development of a systematic approach to therapy has greatly increased our ability to manage these patients. The purpose of this communication is to give an analysis of our approach to the pulmonary intensive care unit.^{1,2}

Facilities

The Pulmonary Intensive Care Unit (PICU) is a four-bed controlled nursing area where patients

are assured of constant observation and of receiving maximal benefit from the specialized care designed to meet their individual medical and nursing needs. In order to provide this ideal environment sufficient room must be provided (minimum of six feet each side of bed center) to accommodate ventilators, resuscitation equipment, fluoroscopy units and rehabilitative efforts. Each bed must be equipped with oxygen, suction, compressed air and space for intravascular pressure and electrocardiographic monitoring. Every effort should be made to provide a bright, cheery environment with windows and sound absorbing materials such as curtains, acoustical ceilings and carpeting. Respiratory failure patients tend to remain in the unit for greater periods of time and are more prone to ICU psychosis secondary to continuous bombardment by high noise levels from ventilators, oxygen equipment, frequent stimulation from suctioning with postural drainage, and by central nervous system stimulation from bronchodilator medications possibly superimposed on hypoxic confusion.

The nursing station must be centrally located so that continuous visual monitoring is possible. The unit ideally should be designed so it is 25 feet or less from the center of the nursing station to bed center or to the supply/utility area, thereby allowing maximum observation with minimum walking. The nursing station must be equipped with remote monitoring having a simultaneous display of each patient's cardiopulmonary data. The monitors should include crisis monitors with a memory loop or delay capacity so that crisis precipitating events can be recorded. The potential for

arrhythmias in acute respiratory failure and chronic airways obstruction is high.³

A laboratory for around-the-clock determination of arterial blood gases immediately adjacent to the PICU is required, since these patients are very unstable. A logistic delay due to laboratory remoteness or unavailable technical assistance is not acceptable. This laboratory can also function as an additional facility for supporting specialized ventilatory studies and sputum examinations.

Close by, in the University Hospital is another specialized nursing care unit (the Progressive Care Unit, PCU) which is designed to allow patients to receive less intense care while being continuously observed and monitored by telemetry for arrhythmias. This facilitates increased rehabilitative efforts while the patient convalesces toward self care. Immediately adjacent to both these units is the conventional nursing unit specializing in completing the comprehensive pulmonary care program. This arrangement maximizes the communications between essential personnel in each stage of the program and minimizes the distance the patient is from any required service.

Personnel

Conducting a comprehensive pulmonary care program is best accomplished by the team approach to management. A PICU medical director is required both professionally and administratively and must be knowledgeable in such areas as respiratory physiology, circulation, acid-base balance, infectious diseases, neurological emergencies and poisonings. The major responsibilities must be the con-

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Dr. Brashear is director of the Pulmonary Medicine Division and professor of medicine, Indiana University School of Medicine, Indianapolis.

This study was supported in part by a contribution from Mr. W. J. Holliday.

tinuing education of the staff, the setting of care standards, and integration of the management of acute respiratory failure. We feel it unwise to separate the primary care physician from the patient during a crisis period; thus, the primary care physician remains in charge of the patient's entire pulmonary care program. Frequent pulmonary consultations concerning alterations in management based upon physiologic principles are made as required for each patient. The pulmonary medicine Fellows, who are already fully qualified in internal medicine, assist with the physiological monitoring of patients, performing special diagnostic procedures, and providing frequent consultation to the primary physicians.

The pulmonary intensive care nurse specialists provide or supervise all details of patient care within the unit. They must be highly quali-

fied with a broad understanding of all facets of pulmonary and cardiovascular problems. This level of expertise is achieved by a six-week, 40-hour-per-week basic training and orientation program in which such topics as artificial airway care, fluid management, electrolyte problems, Swan-Ganz catheters, arterial catheter maintenance technics and applications of respirators are covered. This phase of the educational program is balanced between the classroom and the bedside. In addition, there is a one-week (40-hour) coronary care course specializing primarily in the identification and management of arrhythmias. The nurse is then considered qualified to begin working in the unit under direct supervision of the PICU nurse specialist and is qualified to begin the 60-hour course in pulmonary physiology and care. Topics covered are the physiology of venti-

lation, blood flow, diffusion, arterial blood gas interpretation and the mechanics of ventilators. Available at this point are an advanced coronary care course and continuing educational unit meetings.

A minimum ratio of one qualified nurse for every two patients on each eight-hour shift is maintained. This ratio is frequently exceeded in order to insure sufficient personnel to cover holidays, vacations and continuing education activities.

The respiratory therapist supplies and maintains humidifiers, oxygen equipment and ventilators. The nursing staff supervises all respiratory care and is assisted by the therapist in providing postural drainage, suctioning and ambulation.

The physical therapist is extremely valuable in providing chest percussion, breathing training, strengthening the secondary muscles of



FIGURE 1

Early patient ambulation, being monitored and receiving low flow oxygen in PICU.

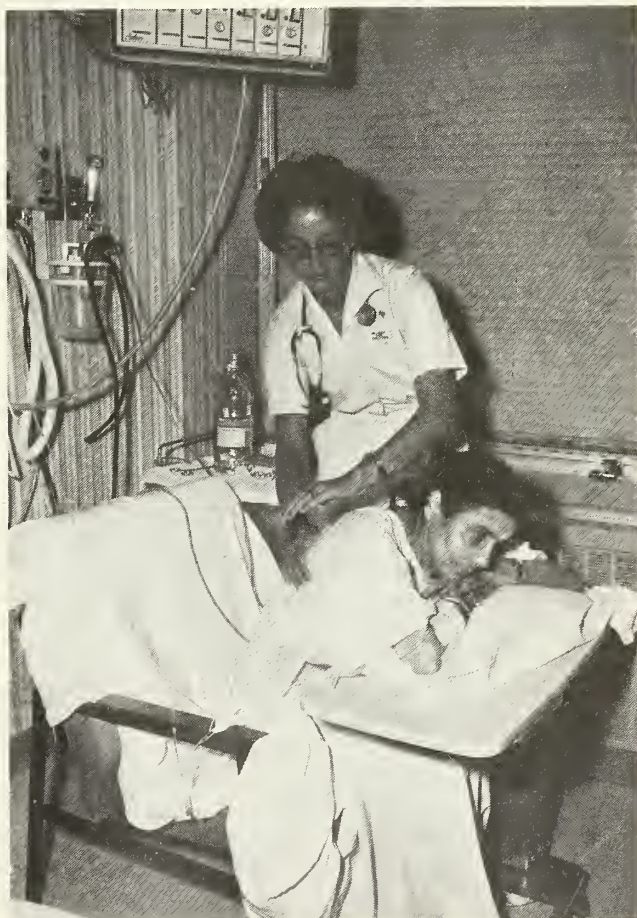


FIGURE 2

Progressive bedside physiotherapy.



FIGURE 3
Artificial airway care by nurse specialist.

respiration and ambulation. The occupational therapist assists in training the patient to carry out the activities of daily living and to practice energy conserving and oxygen sparing maneuvers. This stage of the rehabilitative program begins as soon as the patient is stabilized after the precipitating event. Any unnecessary delay only allows further deterioration of muscle tone and muscle mass. This not only contributes to increased oxygen utilization but increases the risk of complications such as pulmonary emboli and decubiti.

The remaining team member is the social worker, who is essential from the time the patient is admitted to the PICU. Initially she interacts with the family to make an assessment of the psychosocial impact of the patient's hospitalization on the family unit. Frequently we discover the patient has been a wage earner and the family needs direction to an assist agency to help them through a long hospitalization. Occasionally the social worker discovers factors that may have contributed to the patient's acute exacerbation, such as a lack of funds to purchase the prescribed therapy. As the patient improves, the

social worker makes a psychosocial evaluation of the patient's concept of his disease status, ascertains the patient's view of goals toward rehabilitation and eventually assists the patient in applying for vocational rehabilitation if it is required. She also assists the patient in making arrangements for chronic oxygen therapy or equipment for chronic aerosol therapy.

Role

The pulmonary intensive care unit at the University Hospital Center has a complex role in serving the state. Besides providing acute patient care for our referring physicians, the PICU serves as a training model for nurses, medical students, house officers and medical visitors from community hospitals. Technics such as intubation, bedside fiberoptic bronchoscopy, ventilator management and advanced hemodynamic monitoring are performed and taught in the unit. The PICU also serves as an advanced clinical research facility. Bedside hemodynamic measurement using flow-directed catheters to measure pulmonary artery and wedge pressures along with cardiac output monitoring has allowed us

to assess the use of digitalis, bronchodilators and fluids in advanced cor pulmonale. Serial determination of pulmonary compliance has allowed us to more efficiently use mechanical ventilators and to define better criteria for discontinuing assisted ventilation.

Admission Criteria

Any patient, regardless of age, with chronic obstructive lung disease deserves a trial of conservative management including controlled low-flow oxygen, careful pharmacological manipulation and intensive nursing. If this management fails and the patient has a history of a relatively active daily life prior to the episode of acute respiratory failure and has identifiable treatable manifestations of disease, such as heart failure, airway obstruction, infection, pulmonary embolism, then mechanical assisted ventilation should be considered. Patients who are well known by ourselves to have inexorably deteriorated despite intensive efforts at comprehensive care and rehabilitation will usually not be considered for assisted ventilation. Any patient who is suffering respiratory center depression secondary to drugs or any patient with a neuromuscular defect such as Guillain-Barré syndrome is also a candidate for admission to the PICU.

Progression Criteria

As each patient achieves effective unassisted ventilation with minimal oxygen supplementation and without cardiac arrhythmias, he or she is transferred to the less intense care areas to continue rehabilitative programs.

Any patient with an acute pulmonary problem may be referred to the PICU by a primary care physician.

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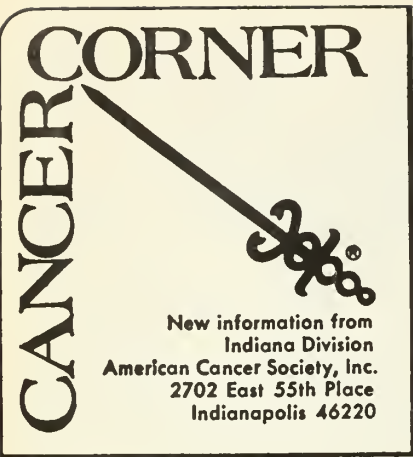
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This conference will concentrate on the advances made in the various areas presented at the first American Cancer Society's National Conference on Human Values & Cancer, which was held in June 1972; these were concerned with the impact of cancer on the patient, the family and the professionals who treat the patient. Emphasis will be placed on interpersonal relationships, rehabilitation, employability, insurability, as well as the patient's right to know his diagnosis and prognosis, his spiritual needs and his hopes for dramatic cures.

The conference will be open to all interested persons, including members of the medical and related professions, the clergy, industry and labor and representatives of those concerned with health care delivery, as well as ACS volunteers.

Additional information is available through the ACS or write: William Markel, M.D., American Cancer Society, Second National Conference on Human Values and Cancer, 777 Third Avenue, New York 10017.

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AMERICAN CANCER SOCIETY— PROFESSIONAL EDUCATION

A high level of skill in the detection, diagnosis and treatment of cancer has been reached in this country. Schools and professional societies are educating practicing physicians, dentists and nurses to an unprecedented extent. However, because of the constantly growing body of medical knowledge and heightened public demand for more and better care, the medical and allied health professions have an increasing need for continuing education in all fields of medicine—and, most especially, in the field of cancer.

The American Cancer Society is the only organization with a sustained interest in and capacity for broad-scale professional education in cancer in the U.S. The Society has created a Professional Education program to provide physicians, dentists, nurses and other professionals with up-to-date information on cancer, supplementing the work of professional schools and societies.

In addition, the Society's Professional Education program encourages health professionals to implement new or special procedures for detection, diagnosis and treatment of cancer, and to recognize the importance of their individual roles in cancer control.

Much of our Professional Education effort is directed toward cultivating a positive attitude, a belief in the curability of cancer through early detection and treatment. Unless all available knowledge concerning the diagnosis and treatment of cancer is utilized, lives are needlessly lost and suffering prolonged. Health professionals can also save lives by educating the public in cancer prevention, detection and treatment.

The medical and allied professions are responsible for anticipating the needs in cancer control. They must support cancer research, adequate professional staffing and

fund raising to further cancer control.

The aim of the Society's Professional Education program, therefore, is to convince the members of the health professions to actively support all the American Cancer Society's programs, which are for the best possible cancer detection and management.

To accomplish this goal, the Society attempts to:

1. *Communicate* information about cancer control via ACS journals, meetings, films and monographs.
2. *Promote* understanding of the cancer problem.
3. *Help* health professionals acquire the skills to detect cancer early and utilize all available knowledge in the management of cancer patients.

4. *Cultivate* attitudes of concern toward the cancer problem which will result in the promotion and use of lifesaving procedures.

A successful Professional Education cancer program also helps other Society programs—Public Education, Public Information, Service and Rehabilitation and Crusade—to fulfill their goals.

For example, when the Society creates a public demand for a new diagnostic test, by educating men and women to its value, there are parallel programs to prepare physicians to recognize the need and usefulness of such a test and to use it properly.

This coordinated effort of Professional Education, like others sponsored by the American Cancer Society, has had a measurable influence on the long-term survival of cancer patients.

WILLIAM M. DUGAN, JR., M.D.
President, Indiana Division
American Cancer Society

Medicine Grand Rounds—Indiana University School of Medicine

Extracted from the Grand Rounds presentation of
January 26, 1977, to the faculty, house officers
and students of the Department of Medicine, In-
diana University School of Medicine.

Nosocomial Gram-Negative Infections

ARTHUR WHITE, M.D.
Indianapolis

TODAY, I plan to review current data of nosocomial infections, to discuss an increasing problem of organisms that are resistant to all or almost all the present commercially available antibiotics and to outline procedures which may keep these problems as low as possible. I will show you data of nosocomial infections derived from surveys by our Infection Control Committee at University Hospitals in November 1976. We are all aware that patients acquire infections within the hospital environment, but many of you may not be aware of the frequency. In November, there were 1,634 patients at University Hospitals. Infections were acquired within the hospital environment by 7.6% of patients. Patients on Surgery Services had a higher rate of nosocomial infections in this particular month, but patients on Medicine, OB-GYN, or Pediatrics, acquired infections at rates between 5 and 10%. (Table I)

The predominant sites of these infections are similar to those published by others. (Table II) Urinary tract infections have been the most frequent site of hospital-acquired infections in all published surveys; bacteremias, in November 1976, were acquired at a frequency of 15

bacteremias per month or a total of 180 patients a year; lower respiratory tract infections occurred frequently.

On the medical service the frequency of various infections was similar; urinary tract infections were acquired by 4% of the patients, bacteremias by 1.7% of patients and lower respiratory tract infections by 3.2%. Clearly, coming into the hospital can be hazardous to your health.

The organisms isolated from hospital-acquired infections are predominantly Gram-negative. (Table III) In the month of November bacteremia due to Gram-positive organisms (usually enterococcus or staphylococci), anaerobes or *Candida* occurred, but the majority of the bacteremias were due to Gram-negative organisms.

Similarly, Gram-negative bacteria were the predominant isolate from urinary tract infections; we had a number of patients who acquired *Candida* within the hospital environment and some Gram-positive bacteria, predominantly enterococcus. (Table IV)

I am less certain about the data on the lower respiratory tract, since sputum cultures may not establish the etiology. If sputum cultures indicate the organisms causing disease, Gram-negatives in the hospital environment are overwhelmingly the predominant organisms responsible for hospital-acquired lower respiratory infections. (Table V)

Table I
INFECTION RATE

Surgery	62/559	11.1%
Medicine	27/348	7.8%
Obstetrics	8/111	7.2%
Pediatrics	26/520	5%

Table II

Urinary Tract	70
Bacteremia	15
Lower Respiratory	24

Table III
BACTEREMIA

Gram-Positive	3
Anaerobes	1
Gram-Negative	8
Candida	3

Table IV
URINARY TRACT

Gram-Positive	14
Candida	12
Gram-Negative	44

Table V
LOWER RESPIRATORY TRACT

Gram-Positive	6
Candida	3
Gram-Negative	18
Unknown	5

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The organisms which were isolated from each major site of infection usually were drug resistant Gram-negative organisms. Although *E. coli* is the most common organism causing Gram-negative infections outside the hospital environment, it is not the most common Gram-negative organism in disease acquired within the hospital. The predominant organisms are ones for which we have few available antibiotics and for some of these we have no effective antibodies. So *Pseudomonas*, drug resistant *Klebsiella* and enterobacter were the three commonest organisms isolated from the sputum from patients with lower respiratory tract disease. (Table VI)

Table VI	
LOWER RESPIRATORY TRACT	
<i>Pseudomonas</i>	6
<i>Klebsiella</i>	3
Enterobacter	3
<i>Proteus</i>	2
<i>E. Coli</i>	2
<i>Hemophilus</i>	2

Although *E. coli* was the largest single organism causing urinary tract infections, we had a very high frequency of *Pseudomonas*, *Klebsiella*, enterobacter and a variety of miscellaneous organisms, so the majority of 40 urinary tract infections acquired within the hospital environment were not *E. coli*. (Table VII)

Table VII	
URINARY TRACT INFECTION	
<i>E. Coli</i>	19
<i>Proteus</i>	8
<i>Pseudomonas</i>	7
<i>Klebsiella</i>	6
Enterobacter	2
<i>Serratia</i>	1
Miscellaneous	8

E. coli was responsible for only one of the 15 bacteremias; enterobacter, which is largely drug resistant, *Pseudomonas*, *Serratia* and *Proteus* were the commoner organisms among the Gram-negative

bacteremia. (Table VIII)

Table VIII	
GRAM-NEGATIVE BACTEREMIA	
Enterobacter	2
<i>Serratia</i>	2
<i>Proteus</i>	1
<i>Klebsiella</i>	1
<i>E. Coli</i>	1
<i>Pseudomonas</i>	1

Within the last three and one-half to six months at the V.A. Hospital and at our other hospitals, organisms were frequently isolated which are resistant to every antibiotic by the usual sensitivity testing. Some of these may represent only colonization of the urinary tract and may not be associated with serious symptoms but among these isolated have been bacteremias which are resistant to all commercially available antibiotics. There have been some 39 patients at the V.A. from whom organisms have been isolated which are resistant to tetracycline, ampicillin, cephalothin, kanamycin, gentamicin, tobramycin, chloramphenicol, nalidixic acid and furazolidin. The newer antibiotic, amikacin, was not tested. Five groups of organisms which were totally drug resistant were *Providentia*, *Proteus rettgeri*, *Klebsiella*, enterobacter and *Pseudomonas*. So we now have, causing problems within our hospital environments, five groups of organisms, not a single organism, which colonize urinary tracts and on occasion cause bacteremia.

There was a 12.5% frequency of gentamicin resistant organisms of all Gram-negative aerobic organisms isolated at the V.A., including *E. coli*. Twenty percent of *Pseudomonas*, 21% of enterobacter, 24% of *Klebsiella*, 50% of *Serratia* and 91% of *Proteus rettgeri* were gentamicin resistant. Ninety percent of Gram-negative bacteria that were gentamicin resistant were also tobramycin resistant. All these data are based upon disc sensitivity but, by the usual criteria, cross resistance is considerable among this group.

What are the controllable sources for either hospital-acquired disease or the acquisition of drug resistance within the hospital environment? There are three sources that should be controllable by the physician. One is the use of indwelling catheters in the bladder. Although the newer closed systems reduce the rate at which Gram-negative bacteriuria occurs, it is clear that even with the best of technic and a closed system, a high frequency of bacteriuria will occur in patients with indwelling catheters for prolonged periods. So, clearly one needs to restrict catheters to essential uses. If one is using a closed system, one should maintain a closed system, not open and change the tubes or valves to allow bacteria in. The use of intravenous catheters is very convenient for administration of I.V. fluids and also is clearly a source of bacteremia. If intravenous catheters are left in place for longer than three days one runs a 2 to 4% risk of an individual patient acquiring bacteremia. So one must look constantly at how long I.V. catheters have been in, they must be placed with good technic and must not be left in for longer than 48 hours. Finally, the use of antibiotics needs to be much more carefully controlled than it has been in the past. All bacteriurias do not need to be treated. If a patient has a Foley catheter for a long time, he will acquire Gram-negative organisms as a cause of bacteriuria; this should not automatically mean that one gives him an antibiotic. What one is going to do with treatment is put pressure of the antibiotics on selecting out multiple drug resistant organisms from the hospital environment. Therefore, before one prescribes an antibiotic one should be certain that the risk of the drug toxicity itself, of epidemiologically adding to the load of the total drug resistant organisms is at least equal to the risk of severe infection. Most asymptomatic bacteriurias should not be trusted.

Dr. Snodgrass: Since the V.A. came in for a good deal of the dis-

cussion, I think I ought to explain the situation that exists to account for the multiple resistant organisms. These patients are almost entirely out at Cold Springs Road on chronic care wards and on permanent Foley catheter drainage. The use of a Foley catheter is unpleasant but necessary. I find, as I make rounds out there every week, if we try to manage these people with an exdwelling catheter, it doesn't work and if you don't control the loss of urine, the skin breaks down and then your patients are dying of infected decubiti so that in some of the patients we end up with permanent Foley catheters. This is also extremely common out at the nursing homes as well. Once you have a Foley catheter in, even though we recently made a great effort to enforce meticulous closed catheter drainage, these people get colonized and so we are left with these two choices. What do we do? What we tend to do is to leave people alone who are asymptomatic and let them just have their colonization with these resistant organisms, treat them when they get clinically infected, if it is possible. The other question is whether we can do something with urinary disinfectants, not antibiotics, that will suppress bacterial growth. Is there any use in any of these procedures, like acetic acid instillation or oral antiseptics, that would help to reduce or stop this colonization?

Dr. White: Earlier studies suggested that the use of acetic acid or local instillation of neomycin polymixin did reduce the frequency with which organisms colonized the bladder. Most of those studies were done with the older open systems and were short term studies. The effect of either therapy over the longer term is more difficult to evaluate. I think most patients within the hospital environment are not going to require long term use of Foley catheters. The breaking of the closed system for local instillation is probably worse than failure to use acetic acid or local antibiotics. I don't have any data on patients who will require Foley

catheters for a prolonged period.

Dr. Daly: Dr. White, what can we expect out of the future with respect to these organisms? You have 12% gentamicin resistant now; is this only the beginning of a problem, with the emergence of a huge fraction resistant? Is there anything known about the forces in the population which will push one way or another?

Dr. White: I think the greatest force is the use of antibiotics. I must admit that I am a pessimist in terms of what is likely to happen in the future, because we have now five groups of organisms with very high frequency of resistance to all antibiotics, also we have some *E. coli* which are also gentamicin resistant. There have been major outbreaks in a variety of hospitals throughout the country of *Klebsiella* or *Proteus rettgeri* infections resistant to all or most antibiotics. Our frequency of 12.5% gentamicin resistant is low compared to data from other parts of the country. So I would bet we will reach the rest of the country before too long.

Dr. Snodgrass: Is there any evidence that Gram-negative organisms can be carried by hospital personnel, as *Staphylococcus aureus* was in previous years? Do we become colonized with these organisms on our skin, etc?

Dr. White: We do become colonized with them on our skin; one of the major ways of transmission from one patient to another patient to another patient, particularly within intensive care units, is the hands of the hospital staff. That has been well documented with *Klebsiella* and for certain other Gram-negative bacteria. So that the bacteria can be hand carried by the personnel not adequately washing their hands in between patients.

There is clearly a Gram-negative people carrier rate in the GI tract so in that sense there is a carrier state; patients and personnel within an environment where drug resistant *Klebsiella* infections are frequent will colonize the gastrointestinal tract or throat with *Klebsiella*. The relative importance

of the staff in transmission from one patient to another has varied from epidemic to epidemic.

Dr. Wheat: I would like to make two points about the cases of drug resistance we have seen. Most of these have been urinary tract colonization, although several cases of bacteremia have occurred due to these resistant organisms. An article in the *Annals* several months ago from the Denver V.A. reported an outbreak of *Proteus rettgeri* infections which were resistant to all antibiotics, including amikacin. We have encountered some organisms which are relatively resistant to amikacin and a few which have not responded to treatment with amikacin to suggest that the resistance is probably significant in these cases. So I suggest that in the future we are going to run into more problems with resistance to even the newer antibiotics.

Dr. Smith: Do you treat someone with bacteriuria with a Foley catheter that has to be in for prolonged periods of time?

Dr. White: No, not in the absence of symptoms. First, you can't do anything. You can change organisms isolated from the urine, but you cannot, if treatment requires a Foley catheter for prolonged periods of time, keep the urine sterile. Second, you clearly do develop a resistant population of bacteria colonizing the bladder, and if the patient should get an infection, it may be almost impossible to treat. I think part of our problem has been that we have treated colonization of the bladder and not infections. When do you treat? If patients acquire bacteremia, fever with no other source, I would treat. I think that we have tended to equate greater than 100,000 colony counts with the need for an antibiotic. You are wasting time, effort and money treating asymptomatic bacteriuria; in addition, you are developing resistant organisms within the hospital.

Dr. Daly: Dr. White, it seems to me about a year ago you spoke here about urinary tract infections and at that time, as I recall, the

message was, even in the absence of catheters, that asymptomatic individuals who were not pregnant with urinary tract bacteria greater than 100,000 did not need treatment.

Dr. White: The need for treatment in asymptomatic patients, even in the absence of Foley catheters, still remains to be documented. I would not treat these patients; I think we have invested a great deal of time and money in looking for asymptomatic bacteriuria; we have treated a large number of these patients. The present data suggest that if patients are asymptomatic, they should not be treated.

Dr. McCarthy: Do I.V. teams who do this professionally do a better job than sporadic people?

Dr. White: The overall data suggest they do. First, that is their job, they do it better and they are not trying to do that while thinking about 6,000 other things; if they are well trained, the I.V. catheter does not stay in very long, whereas the physician may forget it and it may stay in for more prolonged periods of time. Clearly, somebody who is interested in I.V. catheter care and doing that as their predominant job, has a lower frequency of colonization of the tip of the catheter and subsequent bacteremia.

Dr. Daly: I would like to make a point that we must insist that catheters placed into veins be dated; now and then I still see some that are not dated and I believe those not dated should be removed. At least that is what I will do the next time I see one.

Dr. Powell: I was wondering about the significance of pyuria, white blood cells in the urine.

Dr. White: Pyuria occurs in about half of the patients with bacteriuria and probably suggests that there is some reaction between

the patient and his organisms and, therefore, it is probably more than simply colonization. It probably indicates infection rather than colonization; whether you can, in fact, benefit the patient by treatment, I think, remains unknown.

Dr. Lindemann: Is suprapubic cystostomy better than indwelling catheters?

Dr. White: Probably, in terms of bacteremia, if you have good drainage, they work better but not in terms of colonization. Part of the problem with Foley catheters is that they get plugged intermittently and they get changed poorly; with a larger cystostomy tube, drainage should be better.

Dr. McGrath: Do disc sensitivities accurately predict clinical response?

Dr. White: The patterns of drug resistance I have shown are disc sensitivities and they are based upon zone diameters around a given disc. We have not yet tested a large number of these organisms by tube dilutions sensitivities. The limited data available suggest that some of the gentamicin resistant organisms are not highly resistant; that is, they would be inhibited by concentrations that one could achieve in the urine, although not what one could achieve in the blood stream. Serious systemic infections are resistant both in vitro and in vivo. One does have the discrepancy between concentrations of antibiotics one can achieve in the urine with these drugs. Most of our data and data from other places have suggested gentamicin resistant organisms require 20-30 $\mu\text{g/ml}$ for inhibition. You can achieve that concentration in urine, but you certainly cannot achieve it at other sites.

Dr. Daly: Do the patients behave as if the organisms are resistant? That, in the final analysis, is the question.

Dr. White: The patients with

bacteremia have behaved as though the organism is resistant. In urinary tract infections the urine has been cleared of organisms with MICs of about 32 but blood cultures have remained positive in some of these patients in spite of everything we gave them. We may be getting enough gentamicin in the urine to temporarily sterilize the urine, but clearly, with the serious infections, we cannot get enough into the blood streams, lungs, etc.

Dr. Lopert: If you remove a catheter, when should you treat bacteriurias?

Dr. White: I think that depends upon the patient, what other types of underlying renal disease he has and what other types of therapy he has had. But assuming that this is acute urinary tract obstruction from a transient neurological disease or a diabetic who has been in a coma and has had a Foley catheter and was not bacteriuric before. Also, I will assume one does not have other types of foreign materials or obstructions; I think it is worth getting the cultures at the time one removes the Foley catheter, repeating this in about 10 days to see if they clear bacteriuria without therapy. If they don't, it is worth trying to treat them.

I think one of the important differentials would be to contrast the patient who has had a hysterectomy and has a catheter in for a few days postoperatively and has a normal urinary tract otherwise with the man who has retention and residual urine, which would be a totally different problem.

The chronic Foley catheters, most of the time, have been in for a chronic urinary problem and in those circumstances the urinary problem still remains; and though the Foley catheter is the main offender, clearly, renal stones, retention, other local abnormalities also limit our aim of permanent eradication. ◀

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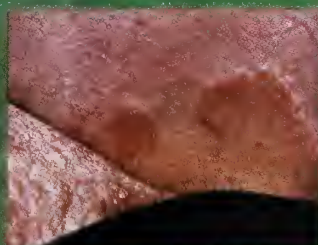
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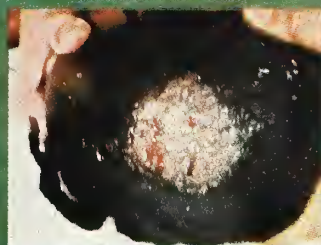
TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



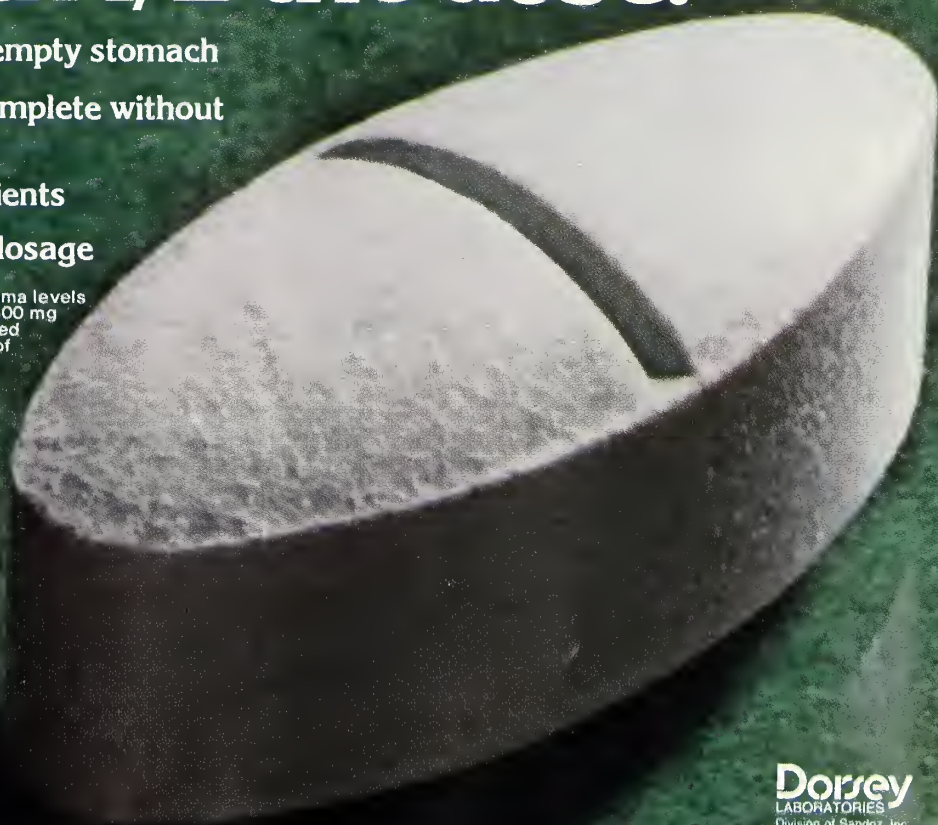
TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

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125 mg

The ½ dose griseofulvin.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG Tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsize griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections:

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis, ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleinii
Microsporum audouinii

Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *NOT* effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5 to 2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral ad-

ministration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress. Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists, however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSEAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potas-

sium hydroxide or by a culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months, toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsize) USP (see ACTION Human Pharmacology).

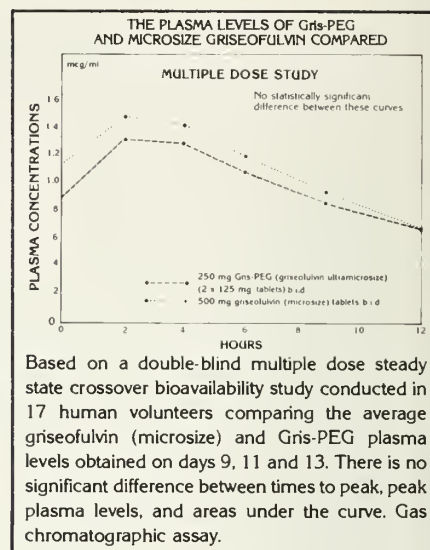
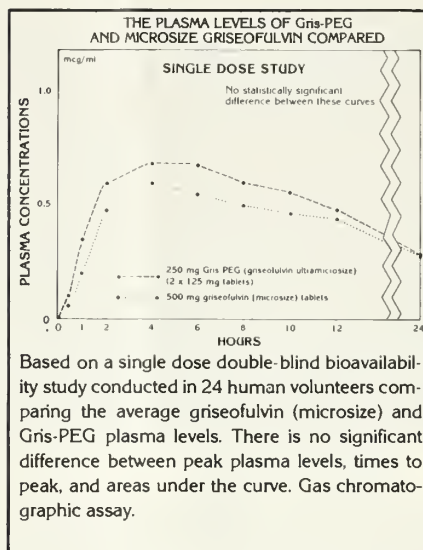
Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis the following dosage schedule for children is suggested. Children weighing over 25 kilograms (approximately 50 pounds) 125 mg to 250 mg daily; children weighing 15-25 kilograms (approximately 30 to 50 pounds) 62.5 mg to 125 mg daily; children 2 years of age and younger, dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin microsize tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin, biologically equivalent to 250 mg of microsize griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsize griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.



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Hypertension Screening, Detection, Treatment and Follow-Up: The Indiana Experience

MYRON H. WEINBERGER, M.D.
Indianapolis

INCREASED public and professional awareness of the existence of approximately 30 million American hypertensives, at least half of whom are unaware of their elevated blood pressure because of the asymptomatic nature of hypertension, has prompted major emphasis in mass screening for hypertension by a variety of health and public organizations. This well-intended approach has been useful in identifying new hypertensive patients. However, it has resulted in a wide variety of new problems which have weakened the benefits of such endeavors.

The previous article in this series on hypertension has pointed out the dimensions and importance of the problem of hypertension. To respond to the growing interest and demand for effective programs in hypertension, the American Heart Association, Indiana Affiliate, established a Task Force on Hypertension approximately four years ago. The Task Force was asked to draft guidelines for the conduct of hypertension screening, detection, treatment and follow-up programs sponsored by the Indiana Affiliate. The present article will deal with several aspects of that effort as well as the information we have obtained and some new approaches which are currently being pursued to respond to this pressing health need.

The Task Force on Hypertension,

of which I served as chairman, was composed of a broad spectrum of individuals involved in health care. These included physicians from our own Hypertension Center as well as representatives from the Indiana Academy of Family Practice, nurse-specialists in hypertension as well as nursing representatives from the Indiana University School of Nursing and the American Heart Association, Indiana Affiliate, the Indiana State Dental Association, the Indiana State Board of Health, and administrative representatives from the American Heart Association, Indiana Affiliate.

Our initial concern was with the recognized inadequacies of simple screening operations which conducted routine blood pressure measurements in areas of public availability (shopping centers, schools, supermarkets, fairs, etc.) without any commitment to ensure medical care for newly discovered hypertensives or mechanisms for providing evaluation, treatment and follow-up. Such exercises, which frequently have been conducted by well-meaning organizations, have been thought to be of little benefit, since they have not traditionally concerned themselves with obtaining effective medical care for those newly discovered hypertensives. Therefore, one of the first guidelines developed by the Task Force on Hypertension was that any screening operation should encompass a commitment on the part of the physicians in the community or county conducting the program to accept patients for treatment.

This has usually been accom-

plished by several means. First, endorsement of the program has been provided by the County Medical Society. In addition, one or more physicians in the community have volunteered to supervise the professional aspects of the program. Finally, the County Medical Society provided a list of physicians who were willing to accept patients for treatment in conjunction with such a screening program, in order to provide a source of medical care for individuals found to be hypertensive but who did not have a physician. The Task Force felt strongly that medical care should be provided by physicians in the community in which the screening program is conducted.

The second major guideline established by the Task Force was that such programs should primarily utilize community resources and personnel in their conduct. This has been accomplished by the generous volunteer efforts of a variety of individuals associated with county heart associations, medical societies, American Red Cross chapters and various other civic and professional organizations.

The third guideline was to insure some method of evaluation of the effectiveness of the program and continuing follow-up of the effectiveness with which patients complied with initial referral to a physician for hypertension and subsequent treatment.

With these guidelines and with the material developed for the program by the American Heart Association, Indiana Affiliate, and support from Regional Medical Pro-

Dr. Weinberger is professor of medicine and director of the Specialized Center of Research (SCOR) in Hypertension. From the Indiana University School of Medicine, Indianapolis 46202.

Table 1: RESULTS OF FOUR COUNTY HYPERTENSION PROGRAMS

County	Population	No. Screened (%)	Hypertensive (%)	Went to M.D. (%)	Treated by M.D. (%)
Jefferson	28,000	5024 (18)	388 (7.7)	129 (33)	98 (76)
Lawrence	38,000	2748 (7)	559 (20.3)	132 (24)	109 (83)
Vanderburgh	164,000	6227 (4)	433 (7.5)	296 (68)	283 (96)
Lake	400,000	5932 (1.5)	1541 (26.0)		
Totals	630,000	19931 (3.2)	2921 (14.7)	557 (40)	490 (88)

grams, pilot programs were conducted in four Indiana counties to evaluate this approach to the problem of hypertension.

These four Indiana counties were chosen because of diverse demographic characteristics to enable evaluation of the effectiveness of different approaches in different kinds of communities. Two had relatively small populations (28,000 and 30,000) and were rural-based, and two counties were chosen because they encompassed a relatively large city (population 164,000 and 400,000). This enabled an evaluation of the relative frequency of hypertension among rural and urban dwellers as well as the racial prevalence of hypertension, since one county (Lake) was largely black. Table 1 tabulates some of the more important data obtained from the program. The four counties listed represented a total population base of 630,000.

The effectiveness of the screening operation in reaching the inhabitants of each county varied from 1.5% of the population screened (Lake County) to 18% (Jefferson County) for an overall penetration of 3.2%. The incidence of hypertension among those screened is quite interesting. Of the tabulated data, there is a range from 7.5% (Vanderburgh County) to 26% (Lake County) with an overall incidence of 14.7%, comparable to national statistics. The difference in the rate of hypertension between counties may be related to different guidelines utilized for the definition of hypertension within each county. In any event, the data do not provide evidence that hypertension is primarily a disease of city dwellers, since Lawrence County, a relatively rural

community, had 20.3% incidence of hypertension among those screened, and Vanderburgh County, which is urban based, had an incidence of 7.5%.

Of the 2,900 hypertensives, 34% knew they were hypertensive and said they were taking medication, but were considered not to be adequately controlled. Ninety percent of the hypertensives said they had a private physician and thus, presumably, had access to medical care. An additional interesting observation was that 48% of the hypertensive population reported having visited their physician in the preceding year. Thus, the physician's office would appear to be a very effective screening site, if blood pressure were to be routinely measured. This could be done by a nurse or trained receptionist as part of the intake process and need not require the physician's time.

An even more interesting observation from this study was the rate at which patients discovered to be hypertensive during the screening program saw their physician. Incidence figures are available for only three of the four counties, as indicated in the table. Documentation of initial visits to a physician, by those found to be hypertensive, was indicated by cards which were given to the patient to be completed and returned to the County Heart Association by the physician. The compliance ranged from 24% in Lawrence County to 68% in Vanderburgh County. The overall compliance rate among the three counties sampled was 40%. This appeared to be much higher than nationally published studies which indicate that in previous hypertension screening

programs in which follow-up evaluation is obtained, at most, 25% of those discovered to be hypertensive ultimately seek a physician's care. However, it was apparent to us that the screening operation had failed to stimulate or motivate 60% of the discovered hypertensives to seek medical therapy.

The final column in the table provides a much more startling finding. This column indicates the numbers of hypertensive subjects detected at the screening programs who went to a physician and received treatment by the physician for their hypertension. In the three counties for which data are available, the physician treatment rate varied from 76-96%, with an overall average of 88%. Thus, it would appear that of those individuals seeking help from a physician after being identified as hypertensive in a screening program, elevated blood pressure was confirmed and effective therapeutic intervention was instituted in almost all cases.

This program taught those of us interested in this problem many important lessons.

1) The incidence of hypertension does not appear to be significantly different among urban and rural populations in Indiana.

2) Hypertension screening can be effectively conducted utilizing the unique resources existent in each community. In some communities, the Heart Association was the major organization involved in the screening program. In other communities, collaboration with other civic organizations, American Red Cross chapters, lay volunteers, church organizations, medical societies, and auxiliaries was extremely helpful.

Thus, it would appear that tailoring the structure of any hypertension screening operation to fit the unique characteristics of the community involved is extremely important. The active and enthusiastic participation of the medical community where the program was conducted was of critical importance. Unless there were adequate numbers of cooperating physicians to accept the newly discovered hypertensive subjects, the program could not be construed as successful.

3) The major problem occurring after the identification of a patient as hypertensive in such a screening program is to motivate the individual to seek medical care. The existence of available medical resources is not enough. In addition, we found that the educational and media information utilized were not adequate to convince more than half of the newly detected hypertensives of the necessity of seeking medical care for hypertension.

4) The response of the medical profession to those individuals discovered to be hypertensive in the screening program and subsequently seeking medical care appeared to be more than adequate in insuring effective therapy.

5) The ultimate effectiveness of the entire screening, detection and treatment program can only be ascertained with techniques designed to measure long-term compliance and follow-up.

Education, Motivation Needed

To improve the effectiveness with which individuals found to be hypertensive sought medical care, inquiries were made to determine what factors influenced their decision not to seek medical attention. We tabulated some of the major categorical responses that were encountered most often: 1) ignorance of hypertension and its complications, 2) financial considerations, 3) time factors, 4) transportation problems, and 5) fear of the unknown medical intervention which may be imposed. Thus, it appeared that the motivational approach

used in the program, which consisted primarily of a nurse telling the individual that his blood pressure was elevated and recommending that he seek the assistance of a physician, along with giving him an educational pamphlet prepared by the Heart Association, was inadequate. We then attempted to develop a more effective approach to the motivation of patients.

A graduate student at the Indiana University School of Medicine, working with our Hypertensive Center, developed an audio-visual aid designed to educate people about hypertension and to emphasize the importance of preventing hypertensive complications. This was presented by a professional actor with graphic representations of victims of various complications of hypertension. This message required three minutes of viewing time.

To evaluate the effectiveness of this technic for motivating newly discovered hypertensives to seek medical attention, a pilot study was performed utilizing a broad population base in Indianapolis. Six thousand individuals were screened for high blood pressure. Those with elevated blood pressures were divided into two groups. One group was simply advised that their blood pressure was elevated, given educational material and told to seek medical advice—a technic similar to that employed in the larger program described earlier. The second group was asked to view the audio-visual message described above. A trained nurse then discussed the content of the videotape with the individual and attempted to arrange an appointment with a physician. The compliance rate in the first group, the percent who sought medical care for their hypertension, was 28%, while that in the second group (who received the special motivational message) was 72%.

This striking increase in motivating individuals to seek medical attention for their blood pressure problems appears to justify the expense of producing and utilizing such a technic. It appears to be very

efficient and serves as an educational and motivational complement to a screening program.

The second issue which we evaluated in the previously described program was the usefulness of repeated blood pressure measurements. In some of the screening programs conducted patients with blood pressures greater than 140/90 at the time of initial screening, but less than 160/100, were asked to return for a recheck at a subsequent time. This was done since it was the belief of the physicians in that particular program that this might avoid needless referrals of people with transient or borderline elevations of blood pressure.

Resources Available

Individuals demonstrating blood pressure greater than 160/100 on the initial screen were immediately referred to their physicians. The data regarding follow-up on these patients raise serious questions. Essentially, only about 20% of individuals asked to return for a recheck of their borderline elevated blood pressure actually did so. Studies performed by other investigators elsewhere have demonstrated that the predictive value of subsequent blood pressure elevations in an individual found to have an initial blood pressure greater than 140/90 on an initial screening was 92%. Therefore, it would appear that programs utilizing multiple screening efforts for rechecking purposes are of questionable value. It must be emphasized that this finding, made in the adult population, is much different from the situation in childhood, which will be discussed in a subsequent article in this series.

Armed with the information which has been derived from the previous screening exercise, the Hypertension Center at the Indiana University Medical Center has recently received funds to support, implement and coordinate continued community screening, detection, treatment and follow-up programs in hypertension throughout the state. These resources are available

to communities that wish them. They must combine the essential components outlined previously of an identifiable organization for the conduct and implementation of the program within the community, utilization of the unique resources existing within a specific community, the endorsement and active participation of the county medical society, and a commitment on the part of the physicians in that county to accept as new patients individuals found to be hypertensive who do not have a source of medical care.

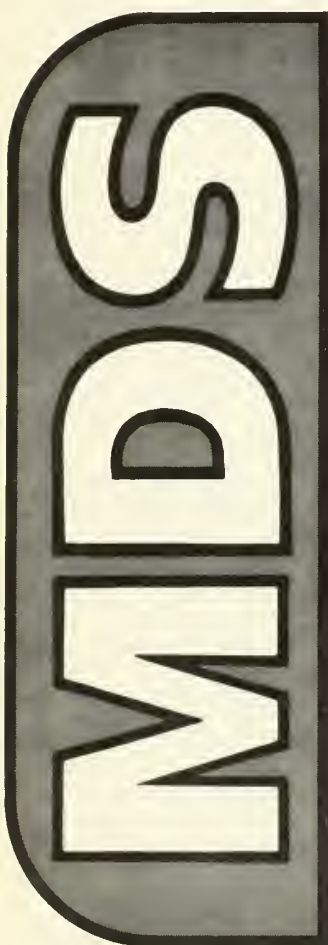
Furthermore, such programs should contain components designed

to motivate individuals detected as being hypertensive to visit a physician for further evaluation and treatment and must have a mechanism for the evaluation of long-term compliance and effectiveness of anti-hypertensive therapy.

The current program also contains support for developing educational programs to accomplish any of the previously mentioned goals. A wealth of experience has been acquired regarding effective and ineffective approaches which have been utilized in various community programs that can be informative

and helpful in designing new programs. It is our firm conviction that an integrated, continued hypertension detection and treatment program by committed individuals, utilizing a variety of resources and expertise, may be extremely effective in extending the limited time and ability of physicians in practice to control this major medical problem.

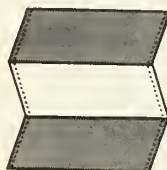
Further information and details regarding the previous, current and proposed programs can be obtained by writing to the Hypertension Center, Indiana University Medical Center, 1100 W. Michigan St., Indianapolis 46202. ◀



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SEMINARS FROM RILEY CHILDREN'S HOSPITAL

A Practical Guide to Pediatric Electrocardiography— Part One

RANDALL L. CALDWELL, M.D.
ROGER A. HURWITZ, M.D.

Indianapolis

Introduction

ELECTROCARDIOGRAPHY in pediatrics helps in the diagnosis of congenital and rheumatic heart disease, and in certain infectious processes involving the heart. The electrocardiogram is essential in the diagnosis and management of cardiac arrhythmias. The pediatric EKG is quite different from that of an adult. For adequate interpretation of the electrocardiogram, it is essential to know the child's age; helpful also are clinical and drug history, cardiovascular physical findings and possible chest deformities. In order to gain maximum data, it is essential to have the standard 12-lead EKG plus additional chest leads over the right chest (V4R or V3R) for adequate assessment of right ventricular activity in the young child. There should also be sufficient length to the tracing to assess possible conduction disturbance or arrhythmia. Since it is difficult to memorize all

normal values as they relate to age, a reference listing these values for children should be available. Several standard textbooks on pediatric cardiology tabulate these norms.^{1,2}

QRS Axis

The QRS complex changes dramatically from birth to adulthood. At birth, the QRS axis is oriented anteriorly and to the right because of the right ventricular predominance. This axis then shifts leftward and posteriorly. By three months the QRS axis is approximately 70° and is in the frontal plane. The axis then shifts slightly more to the left (average QRS axis 60°) and becomes more posteriorly oriented. The greatest change has occurred by three to five years of age. Left axis deviation is quite unusual and suggests endocardial cushion defect, tricuspid atresia or single ventricle complexes.

T Wave

At birth, the T wave is oriented anteriorly (average axis 130°); T_s upright in V4R and V1 of the precordial chest leads. This axis quickly shifts posteriorly by 24-48 hours of life. The T wave axis then gradually shifts in a posterior-anterior direction such that 4% of

young adolescents may have an upright T wave over the right precordium (V1). Between the ages of two days and nine years, an upright T wave in the right precordium should be considered abnormal and indicative of right ventricular hypertrophy.

P Wave

The P wave axis changes very little during childhood and has an average axis of 60° with the impulse traveling from the sinoatrial node to the atrioventricular node in an inferior, lateral, anterior direction. The P wave should always be upright in standard limb lead I. If it is inverted in I: 1) the leads have been reversed during the recording, 2) there is atrial inversion such as dextrocardia, or 3) the sinoatrial node is not the initiating pacemaker and the pacemaker site may be in the junctional area. The duration of the P wave in children is 0.06 ± 0.02 seconds. The maximum height of the P wave in lead II is 2.5 mm, but may be taller in leads V4R and V1. The P wave shape is usually rounded in II and diphasic or inverted over the right precordium (V4R or V1). The P wave over the left precordium (V5 or V6) is usually upright but low. Peaked

Dr. Caldwell is a Fellow in pediatric cardiology, Department of Pediatrics, and Dr. Hurwitz is professor of pediatrics (cardiology), James Whitcomb Riley Hospital for Children, Indiana University School of Medicine, Indianapolis 46202.

(greater than 2.5 mm) but narrow P waves in II and III with pointed P waves in the right precordium (VI) is usually indicative of right atrial hypertrophy (P pulmonale). Notched, low, prolonged P waves in I and II are indicative of left atrial hypertrophy (P mitrale).

Ventricular Hypertrophy

Perhaps one of the most frequent uses of the electrocardiogram in children is in the evaluation of ventricular hypertrophy. Though the

net voltage of the QRS complex is frequently used to determine hypertrophy, it must be remembered that this voltage reflects the thickness of the ventricle but may be influenced by the distance of the heart from the electrode. Thus, caution must be used in diagnosing ventricular hypertrophy on QRS voltage alone.

Right axis deviation is usually suggestive of right ventricular hypertrophy; however, left axis deviation in children is an unreliable sign of left ventricular hypertrophy.

Right atrial enlargement (P pulmonale) in the absence of tricuspid atresia or tricuspid stenosis is indirect evidence for right ventricular hypertrophy; left atrial enlargement (P mitrale) in the absence of mitral stenosis suggests left ventricular hypertrophy. Right ventricular predominance in infancy is expected. Left ventricular predominance suggests left ventricular hypertrophy. The reverse is true for the older child and adult.

A QR pattern over the right ven-

Table 1. The Mean Electrical Axis of P Wave, QRS Complex and T Wave
(Modified from Ziegler)

	P			QRS			T		
	Av.	Min.	Max.	Av.	Min.	Max.	Av.	Min.	Max.
0-24 hrs.	60	-30	90	137	75	190	77	-10	180
1 day-1 mo.	58	0	90	116	-5	190	37	-10	130
1-6 months	56	30	90	72	35	135	44	0	90
6 mo.-1 yr.	55	30	75	64	30	135	39	-30	90
1-5 years	50	-30	75	63	0	110	35	-10	90
5-12 years	47	-30	75	66	-15	120	38	-20	70
12-16 years	54	0	90	66	-15	110	41	30	90

Table 2. Criteria for Right, Left, and Combined Ventricular Hypertrophy
(In the absence of a bundle branch block)

RIGHT VENTRICULAR HYPERTROPHY	LEFT VENTRICULAR HYPERTROPHY	COMBINED VENTRICULAR HYPERTROPHY
Abnormal QRS voltage *1. R wave in V ₁ > 15 mm (aver age 12 months) **2. S wave in V ₆ > 9 mm (aver age 1 month)	Abnormal QRS voltage **1. R wave V ₆ > 35 mm **2. S wave V ₁ > 20 mm **3. Sum of R wave V ₆ and S wave V ₁ > 45 mm	***1. Positive criteria for RVH and LVH **2. Positive criteria for RVH with normal R voltage V ₆ **3. Positive criteria for LVH with R/S ratio > 1 in lead V ₁
Abnormal QRS configuration ***1. qR pattern in V ₁ **2. rsR' pattern V ₁ with R' taller than initial r (dilatation with or without mild hypertrophy) ***3. Onset of intrinsicoid deflection V ₁ > 0.03 sec (onset of downward deflection from peak of R wave) **4. Totally upright deflection (R) V ₁ (after 1 year) *5. R/S ratio V ₁ > 1 after 10 years **6. R/S ratio V ₆ < 1 after 6 months	Abnormal QRS configuration ***1. QS configuration V ₁ **2. Deep Q wave (> 4.5 mm) V ₆	*4. Very large mid-precordial voltages, with R+S > 50 mm in two consecutive leads (Katz-Wachtel phenomenon)
T wave changes ***1. Upright T wave V ₁ after 4 days until 9 years **2. Deeply caved negative T waves associated with tall R wave V ₁	T wave changes **1. Tall thin peaked T wave V ₆ (volume overload of left ventricle) ***2. Inverted T wave V ₆	
P wave changes (right atrial enlargement) ***1. P wave > 2.5 mm lead II **2. Upright P wave > 3.0 mm lead V ₁	P wave changes (left atrial enlargement) ***1. P wave with 2 peaks 0.04 sec apart in lead I, II, or V ₆ **2. Biphasic P wave V ₁ with large terminal negative deflection	

The relative importance of each finding is indicated by asterisks (the greater the number of asterisks, the more reliable the criterion). Voltage and R/S ratio criteria assume relatively greater importance the more they exceed normal values. Many of the criteria listed are those of Nadas, and Ziegler.

tricle (V4R or VI), a positive T wave in V1, or a monophasic R wave in V4R-V1 reflects right ventricular hypertrophy. In left ventricular hypertrophy there may be a deep and wide Q wave (depth > 4.5 mm) in V5 and V6, a tall R wave over V5 and V6, and a deep S wave over V1. In severe left ventricular hypertrophy there may be flattened

or inverted T waves in V5 or V6. (Table 2) In chronic cardiomyopathy there may be left or combined ventricular hypertrophy, T wave changes and conduction disturbances.

Q Wave

In general, the size of the Q wave is of no particular significance in children; however, a Q followed im-

mediately by an R in the right precordium (V1 or V4R) is always abnormal and indicates right ventricular hypertrophy. In an infant with the appropriate clinical findings, a deep and wide Q wave over the left precordium (I, AVR, V5 or V6) is almost pathognomonic of an anomalous left coronary artery or myopathy. ◀

From THE JOURNAL 35 Years Ago

The pleasurable although toxic habit of the use of tobacco constitutes one of the most formidable public health problems of all times.

Cigarette smoke is a variable complex of chemicals, some producing local irritant effects, others showing marked systemic actions. The chief systemic poisons are nicotine, carbon monoxide and arsenic. The principal local irritants are acrolein, formaldehyde and formic acid. The tars and resins are carcinogenic. Lip and tongue temperature may reach 112 to 140 F, if three fourths of a cigarette is smoked.

Cardiovascular responses to tobacco are rapid and marked. Inhalation of one cigarette has caused the heart to beat 13 to 23 times more per minute, has resulted in blood pressure elevations of systolic 10 to 39.7 mm of mercury and diastolic of 7 to 28.1 mm, and in marked constriction of arterioles (demonstrable in the retinal vessels) which lasts one-half to one hour.

Four cases of angioneurotic edema involving the lips, eyelids and other parts have been reported from the use of tobacco. General muscular efficiency is lowered, with a slowing of movement and diminution of the power of contraction in slight to moderate tobacco use. Heavy and fatal doses first bring on incoordination, then twitching and clonic convulsions, with death.

True addiction with withdrawal symptoms is seen.

It is a well-known fact that cancer of the larynx, pharynx and lower respiratory tract are more common in smokers than in non-users.

It is a hideous fact that tobacco coronary heart disease is taking an ever-increasing toll of our younger men. The incidence of coronary heart disease as well as its severity is in proportion to tobacco use. . . . A needless tachycardia and hypertension is produced, greatly overworking the heart, and at the same time the oxygen supply is reduced, thus intensifying the cardiac insult.

One wonders why tobacco products are not subject to control by the pure food and drug laws. . . . Our eminent pharmacologists would not include tobacco in their textbooks if it were not considered to be a drug.

Tobacco is exceeded only by the income tax and profits tax as a source of revenue in the United States. "Tobacco Intoxication," Byron Kilgore, Jr., M.D., Danville (now Fort Wayne), JISMA, June 1942.

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Guest Editorials

Osgood-Schlatter's Disease —A Clinical Diagnosis

OSGOOD-SCHLATTER'S Disease is a clinical diagnosis, not an x-ray diagnosis, to my thinking.

It is normal for the epiphysis of the tibial tubercle to be unfused in an adolescent, primarily around 13 years of age. X-ray examinations of the knees show this normally unfused tibial tubercle and neither establish nor confirm the diagnosis. It is the experience of many physicians to get x-ray examinations of both knees and find the non-painful one "looking worse"—having a less fused epiphysis for the tibial tubercle than the painful knee. It is clear to many physicians that x-ray studies of the knees are of no value in making the diagnosis of Osgood-Schlatter's Disease.

Why are x-rays of the knees ordered then?

To rule out a malignant tumor.

Whether the concerned mother mentions it or not, she usually knows that malignant tumors of the knee are most common in adolescence, and that they are often painful. And she is scared. She wants x-rays to show that there is no malignant tumor. Pain from a growing, unfused epiphysis that is being pulled on more by the patellar tendon of an active adolescent is a secondary consideration.

Often the mother won't mention

it, and the attending physician won't mention it on his x-ray request when he asks for an examination of the knee and writes "Osgood-Schlatter's Disease" as the reason for the x-ray study.

But if the radiologist is aware of this fact of life, examines the knee for a sarcoma, finds none, and says that there is no evidence of a tumor in his report, he will meet the main need of the concerned parent and the attending physician—even though it was never mentioned.—**R. J. Noveroske, M.D., Evansville.**

On Rearing Children, Monsters and Dogs

IT is obvious that children are a social necessity; complete absence of them would lead in a single generation to racial suicide. Since they are a racial necessity, I am not in favor of exterminating them; rather, I am in favor of increasing their numbers. They can be a source of great joy to those who love them, they are a lot of fun to be around, and, in addition, who is going to "knock" the pleasure of cohabitation with the young and cute females involved in their procreation?

So, having created the little ones, let's teach them and ourselves to live together in a mutually satisfying relationship. This requires learning on the parts of parents and children.

I claim that as a general rule parents are more knowledgeable about life and living than are their infants; the obvious corollary follows: it is up to the parents to start teaching and training at this time. There may come a time when the roles are reversed, and the children are smarter than the parents, but such time is far into the future. To permit infants and small children to rule the family smacks a great deal of the idea about letting the monkeys run the zoo; I doubt their ability to do a good job.

If one were to buy an expensive pup dog and take him home, feed him, provide shelter and veterinary care for him, but make no effort to train him, one could expect that when the dog reached maturity, one would have an unlivable monster on one's hands. One could expect the dog to snarl at its owner, bite the children, defecate on the rug, urinate on the floor behind the bed, and, on the whole, be a monster that no one could live with comfortably, or even tolerate being with except for very short periods of time. Can one expect his dog to learn "good dog behavior" from association with other untrained pups?

It is my belief that the reason so many of us parents end up with adolescent "monsters" in our homes is the "cult of permissiveness" in our child rearing customs. We let the children do as they wish without adult guidance, both at home and at

school; we take the easy way of "combing the kids from our hair" by letting the TV screen serve as babysitter and instructor; we fail to build ourselves into them. In fact, we fail to build much of anything into them; we permit the "cute little animal" in them to grow unguided, unchecked and unsocialized, after a few years we seem to be amazed and shocked that we have such unguided, unchecked and unsocialized "ugly big monsters" living in our homes. Why should we be so amazed and shocked at such results?

When we look around the mini social groups with which we associate (neighborhoods, churches, PTAs, employee groups) we find occasional big children, adolescents and young adults who are a joy to behold, to know and to be associated with; we find some well-trained and well-behaved "human beings" amidst the majority of "monsters." If we look into the homes and families that produced such "nice offspring," we will usually find parents no smarter than ourselves, but homes and parents where the children were trained and taught to be well-behaved people. We usually find parents (or responsible adults filling the parent role) who said "No" and insisted on "No" to their children when that was the best answer for the children. At times, the well-trained child needed a firm pat low down on the backside for his own benefit—and received it.

In rearing children (or dogs), much praise and encouragement is vitally needed; occasionally absolute discouragement is also needed. I am convinced that there is a place for a swat on the hindquarters of children—not so much for punishment as for distraction. There seem to be few things that distract a child from ill-advised behavior as effectively as a "stinging seat of wisdom." The majority of "pats" on the back sides of children should be high up and gentle; the firm "pats" lower down should be few and far between, but should be used when appropriate. Each such use should cause more pain and distress in the donor than it does in the recipient; if not, it is probably cruelty to children.

In short, what I am urging is that we apply as much time, effort and loving care to the rearing and training of our children as we do to the training of our domestic animals!—
L. A. Arata, M.D., Shelbyville.

Clutching at Apricot Pits

Producing Laetrile is only slightly harder than making a pot of coffee from raw beans. Apricot pits are dried and husked; the seed kernel is ground up and cooked with a certain benzene compound that extracts the Laetrile.

But the manufacturing process is the only simple thing about Laetrile, a cyanide-related substance of no known efficacy for which a few cancer patients have claimed amazing curative properties.

Eminent institutions have put Laetrile through cancer tests on rats and mice and found no evidence of health improvement. Researchers have tried without success to substantiate claims of cured human cancer patients. The drug, whose other chemical name is Amygdalin, lacks even a shred of clinically demonstrated worth, except for some evidence that it tends to increase appetite just as other cyanide compounds do.

Laetrile is banned in the United States under the Food and Drug Administration's efficacy standards:

No matter how harmless a drug may seem to be, it cannot be used in this country unless someone can show that the substance has some medical value. The National Cancer Institute has just announced that it may launch a new study of Laetrile's value, but that work will take months or years.

As a result, hundreds of desperate American cancer victims troop regularly to Laetrile clinics in Tijuana and elsewhere to get injections, looking to the drug as their only faint hope for recovery. Others spend an estimated \$700 to \$800 a month for Laetrile made by bootleg manufacturers or smuggled into the country by unscrupulous promoters.

Should the ban on Laetrile be dropped? Many people think so, arguing that basic freedom and plain sympathy demand letting hopelessly sick people use even this costly and medically baseless last resort—if having tried it will ease their sorrow and pain. That is sensible so long as legalizing Laetrile doesn't foster the growth of medical quackery.

Dr. Franz J. Ingelfinger, editor of the *New England Journal of Medicine*, has urged the legalization of Laetrile even though he considers it "another one of those quack cures that sweep relentlessly through our volatile society."

A cancer patient himself, Ingelfinger said in a recent essay, "Perhaps there are some situations in which rational medical science should yield and make some concessions. If any patient had what I thought was hopelessly advanced cancer, and if he asked for Laetrile, I should like to be able to give the substance to him to assuage his mental anguish . . ."

Continued banishment will only reinforce the Laetrile proponents' zeal as well as their suspicions, Ingelfinger noted. He proposed a two-year trial to assuage those suspicions and also allow the gathering of enough clinical data to give Laetrile a full study.

Already six states have legalized Laetrile, and a bill to allow its use



"HE'S THE ONLY DOG ON MY ROUTE WHO GIVES ME A SPORTING CHANCE."

in California is pending in Sacramento. Meanwhile, a bill motivated by the Laetrile controversy is pending in Congress. This sweeping measure would set aside the FDA's entire efficacy standard, allowing any drug, including Laetrile, to be marketed so long as tests point to no harmful effects.

We think the federal measure is lacking in caution. No drug is harmless if its easy availability from unethical doctors or distributors diverts a patient from seeking more meaningful therapy in time to save his life. Dismantling the efficacy standard would open the floodgate to all kinds of nostrums and phony cures. Phony cures cause real and unnecessary deaths.

Similarly, California Senate Bill 245—the proposal by Sen. William Campbell (R-Whittier)—is flawed by the paucity of its safeguards against quackery. The bill says a physician may prescribe Laetrile if he has told the patient, in writing, about the risks and reputed benefits of this and other kinds of treatment. The doctor must also urge, but need not require, the patient to see another doctor who is a cancer expert.

We think the restrictions should go further: Laetrile's use should be allowed only for terminal cancer patients who ask for it.

The law has no business denying a citizen's dying wish to grasp at harmless straws. But neither should the law subvert medical care in the name of freedom, lulling patients into thinking they are being treated when they aren't.—Copyright © 1977 Los Angeles Times.

Editorial Notes . . .

The American Foundation for the Blind lists several devices which enable blind persons to comprehend printed matter. One is the Kurzweil Reading Machine which scans printing and produces audible speech. The user may read words, lines, ask the unit to spell out words, and control reading speed, pitch and volume. Another is Telesensory Systems' Optacon which converts

scanned printed matter into tactile stimuli capable of being sensed and recognized by the finger. A third device, an attachment to the Stereotuner, converts scanned printing into audible tones. Improvements are expected to produce portable units with better speech output and with the ability to scan a variety of type faces and, eventually, to interpret handwritten material.

An automobile may be built from spare parts, but it is the most expensive way. A wrecked car today that requires replacement of one-fourth of its parts is a total loss. It would cost \$21,471 to replace all the parts of a car with a factory price of \$4,681. Last year it would have cost \$19,979—the price differential is going up.

Automated karyotyping is here and automated chromosome analysis is on the way. Also, preparation of the microscopic slide is semi-automated. The computer-controlled microscope controls its stage in three dimensions to perform automatic focusing and search. The final karyotype picture comes out in traditional form after the operator has approved it.

Dieting to lose weight is a process easy to prescribe and difficult to follow. The difficulties have motivated a thousand gimmicks and special diets. Group therapy is one of the effective aids. Walter Winchell was the sponsor of the best dietary advice. "Fad diets are the bunk. All food is fattening. Everyone should eat a balanced diet. Those who wish to lose weight should eat less of it."

While the number of male smokers has steadily decreased, more teenage girls and young women are smoking now than ever before. And smoking more than formerly. MEDIX, the weekly half-hour TV series dealing with medicine and health, will have a special program

during the second week in August which will examine this phenomenon. The presentation, titled "The Feminine Mistake" is produced by Burroughs Wellcome Company in cooperation with the American Cancer Society. Local TV listings will carry the date and channel.

The Food and Drug Administration was accused by some of its employees recently as being biased in favor of the drug industry to the point of approving drugs which were, in fact, either not safe or not effective. The charge has been meticulously investigated by The Review Panel on New Drug Regulation. The final report of the Panel was issued in June. The main finding was "FDA is neither pro- nor anti-industry in its review and approval of new drugs."

Two other findings: "The system of drug regulation that required premarket clearance of prescription drugs based on evidence of safety and efficacy is fundamentally sound—but risk-benefit ratios should be considered." Also: "FDA's implementation of drug regulation needs substantial improvement in *four major areas*—opening the drug review process, increasing the agency's scientific capability, improving standards and procedures for premarket approval of new drugs, and increasing agency authority after a drug is marketed."

Stanford Research Institute estimates that some four million Americans suffer from peptic ulcer disease and that \$3.2 billion is spent in medical care or in lost earnings as a result. At one large teaching hospital costs averaged \$238 per day for ulcer patients. It is estimated that around 40,000 Americans are unable to work at all because of ulcer disease.

The AMA jail health project shows signs of producing high dividends already. Examination of 641 prisoners shows 12.9% with positive test results for tuberculosis, 5.9%

with positive results for syphilis and 30% with results indicative of liver malfunction and possibility of hepatitis. Ninety percent of the inmates surveyed had at least one medical complaint and in 60.9% of these follow-up care was recommended.

The National Cancer Institute has modified guidelines for the use of mammography in cancer detection. The recommendation is that mammography for purpose of screening be not used in women age 35 through 49 except where there is a personal history of breast cancer or a history of breast cancer in the screenee's immediate family (mother/sister).

Comparisons of the consumer price index of medical care with other important items are increasing in number and importance. The CPI for medical care is now 184.7. The CPI for per-capita income after taxes has more than doubled since 1967 and now stands at 202.0. Many expenditures in the medical care field are discretionary and, most certainly, are made with less restraint when personal income is up.

Federal bureaus often issue orders which are in direct conflict with orders of other federal bureaus. Now we have one bureau which, within itself, issues conflicting opinions, one thing for one group, the opposite for another

group. The Federal Trade Commission has ruled that relative value scales are the same as price fixing and are, therefore, illegal for use by physicians. The courts are agreeing. This, despite the fact that relative value systems are useful only and are used only to denote the relative value of a medical procedure as compared with other medical procedures. Now, the FTC has confirmed this opinion and, at the same time, has ruled that health insurers, both private and governmental, may develop relative value schedules for assessing the reasonableness of charges. Doctors developed relative value scales as a means of determining reasonable fees. So, where is the difference?

The most recent Firestone Index of pharmaceutical sales shows that sedatives, anti-obesity drugs and hormones declined in popularity between 1949 and 1975. Sedatives are down from 5th place to 17th; anti-obesity drugs dropped from 12th to 16th; and hormones, which were the fourth most popular drug in 1949, declined to sixth. Vitamins fell from 2nd to 10th place.

John H. Schriever, vice president of Lederle Laboratories, warns that public health care in the future will suffer unless unjustified government regulation is halted. He describes the combination of being victimized and being intimidated as "victimization." He recommends that everyone concerned start challenging gov-

ernment regulations. The patient/consumer, who is the one who will suffer the most eventually, should be informed about the situation. Everyone should write to and talk to their elected representatives more and more.

Researchers in the electrical engineering department of Purdue University are planning a new medical diagnostic device which will be intended to produce enlarged, three-dimensional, full color, holographic visualizations of internal organs and tissues—perhaps even in natural physiologic motion. One problem, yet to be solved, is the finding of a medium suitable for registering the image.

The expectation of life at birth in the United States is improving steadily. It reached a new high of 72.8 years in 1976, after an increase of 2.1 years since 1970. A male child born in 1976 has an expectancy of 68.9 years; a female child 76.7 years. Improvement recently has been more pronounced in the non-white population.

Today, 39% of adult males and 29% of adult females are cigarette smokers. From 1968 to 1975 percentage of physicians who smoke has decreased from 30 to 21. For dentists the figures are from 34 to 23. Pharmacists have decreased in the same time bracket from 35 to 28. ◀

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The AMA Washington Office: What It Does and How It Functions

PHYSICIANS feel frequently that the federal government is far too much involved these days in their profession's and patients' destinies.

Indeed, physicians can hardly be blamed for feeling this way.

Increasingly, the Congress demonstrates its preoccupation with health and medical care by tinkering with it. Congress schedules and holds hearings, debates and passes bills, and functions overall so industriously that of the 25,000 or so measures introduced into each Congress, some 10% bear directly or indirectly on health.

Once the new laws are on the books, the administrative agencies take over the business of implementation. That means that regulations must be drafted and argued and adopted.

Neither legislation nor regulation can be ignored. As true as it is that the power to tax is the power to destroy, so the power to regulate can be the power to paralyze, to strangle and, ultimately, to destroy. Intelligently drawn regulations can make poor laws workable and badly drawn regulations can make good laws unworkable.

And so the symbiotic relationship in laws that exists between the legislative and the executive branches of the federal government demands unrelenting vigilance.

The American Medical Association exercises that vigilance, and has since 1944, through a Washington Office.

The Washington Office has a

This report was written by the American Medical Association's Washington Office for *Connecticut Medicine* and is published here with the permission of J. Alfred Fabro, M.D., editor of *Connecticut Medicine*.

number of functions:

*It is an intelligence-gathering organization, charged with the responsibility of staying abreast of Congressional thinking, planning and action; and with maintaining an equally close vigil on the doings of the various executive departments and agencies.

*It is a podium from which to disseminate AMA thinking on a variety of subjects of concern to government—AMA agreement, disagreement, caution, modification, proposed solution or information to lawmakers and media alike.

*It is a mechanism for providing service to legislators and administrators, an on-the-spot AMA presence, a two-way conduit between those who make and administer the laws and the medical professionals who must live with the laws and try to make them work.

There is no perfect way for the Washington Office to go about its complex tasks. In consequence, neither table of organization nor administration method has remained immutable over the years. Efforts to increase the effectiveness of the Washington Office are always being made.

But, in general, the Office works as a modestly staffed, highly specialized group of experts who serve as the extended arm of the AMA in Chicago.

Today the Washington Office is a unit of the Division of Public Affairs, linked so closely with Chicago by tielines, teletype and thermofax that contact is continuous throughout the working day. And often goes on well after the day has ended.

Under the Washington Office

Director and his deputy are these key people:

A director and four assistant directors of the Department of Congressional Relations. Between them, these five men cover all 535 members of Congress and their staffs; and work particularly closely with the staffs and members of those key committees through which the bulk of important health legislation must pass.

Each lobbyist is also assigned the responsibility of maintaining liaison with a number of state medical societies.

The deputy director of the Washington Office is also director of the Department of Federal Affairs, which works closely with the departments and agencies of the executive branch. Within this department are also two legislative attorneys who research major federal legislation affecting health, attend hearings, monitor the *Congressional Record* and the *Federal Register*; work closely with the Division's Legislative Department back in Chicago, touch bases frequently with the lobbyists, and help staff all meetings of the AMA's Council on Legislation.

A four-man Communications Department deals with media, covers the Washington scene for *AM News* and *JAMA*, helps Congressional staffs with research or speech material, etc.

Supporting all this broad activity is the library, which serves staff, the general public, Congress and the Federal agencies.

So much for the administrative unit: how does it work to reflect AMA policy?

First, the AMA's legislative objectives are set by its House of Delegates, usually in broad policy

guidelines. These guide the AMA's Council on Legislation when the time comes for it to review the many and varied issues developing in government.

The Council then recommends to the Board of Trustees that legislation be proposed, supported, amended or opposed. Once the Board has acted, its decisions are sent to the Public Affairs Division for appropriate action in Chicago and Washington.

It is in this way that practicing physicians' viewpoints and supporting arguments are made known to the legislative and executive branches of government.

By and large, this method has proved effective. Some AMA viewpoints are indeed rejected. But many are accepted; and many more help shape compromise positions.

The Congress usually welcomes AMA viewpoints because it recognizes that the public cannot be well

served unless all portions of a question are carefully weighed. Thus, such independent forces as organized medicine contribute to the public weal by studying and questioning what government does and does not do.

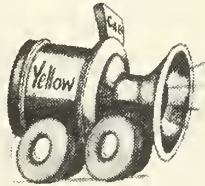
In summation, the AMA-Washington Office is an important component of a complex mechanism designed to convey the individual American physician's viewpoint to the federal government. ◀



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BOOK REVIEWS

MANAGEMENT OF THE UROLOGICAL PATIENT

Robert Morpeth Jameson, K. Burrows, Beryl Large, Churchill Livingstone Publishers, Edinburgh, London and New York, 1976; 249 pages; \$13.50.

Frequently there is more useful information for the practicing physician from a book for nurses than from other esoteric, scientific communications. Unquestionably it is true of this manual, written by an English genitourinary professor and two nurses.

It is published in soft cover (and consequently has a civilized price in this age of \$100 textbooks) with 14 chapters, small appendix and index. The range includes laboratory procedures, catheter care and usage, nursing management of infections, genitourinary injuries, terminal patient care and a detailed final section on renal dialysis. This last contains a flow sheet for setting up a hemodialysis unit.

Although directed to the hospital nursing and ancillary personnel, the authors state in their brief preface, "The aim . . . is to explain basic procedures . . . for patients with urinary tract disease." Thus they vouch to consider that oft overlooked hospital essential—the patient. Let no one assume, however, that this is a simple text, for never is the reader intellectually patronized; rather it is assumed that he has a scientific foundation, if not a doctorate in medicine. A weighty amount of information and practical advice is presented.

As with some British medical texts I have perused, it is written in pleasant style with panache and even a soupçon of wit. The end of each chapter gives some smashing advice under the heading, "Points to Ponder." The authors are a little dogmatic but perhaps this is not of itself a defect in a book for nurses.

Altogether a cogent production that could be advised reading for resident and nurse alike. I will ask my urologic nurse to read it, especially those chapters on catheter care, endoscopic instruments and their care and nursing the terminal patient. In the future it will be a reference book on the urologic hospital service. Lastly, the urologist whose professional duties include nursing education (and who doesn't do at least this modicum of teaching?) would discover a precious lode to be mined in this modest but competent volume.

It is a bargain at the asking price.

RODNEY A. MANNION, M.D.
LaPorte

MIND AS HEALER—MIND AS SLAYER

Kenneth R. Pelletier, Dell Publishing Co., New York, 1977; 366 pages, with illustrations; \$4.95.

In the last few years there have been a number of books published on the relationship of the mind to physical disease. This is one of the better ones and although it was written primarily for the layman, it can be highly recommended to all physicians. The book is divided into five parts. Part I discusses some of the stresses modern man is exposed to and how these affect his health. Stress-induced anxiety is widespread and millions of Americans are taking tranquilizers. The learning of

relaxation technics may be the solution to handling stress. Part II discusses the psychophysiology of stress—the so-called fight-or-flight response. It goes into more detail about the types of stress individuals experience and ways of evaluating one's own level of stress.

Part III discusses how certain diseases relate to an individual's personality and the amount of stress he experiences. These include heart disease, cancer, arthritis and migraine headaches. Part IV goes into technics of controlling stress. These include meditation, autogenic training and visualization and biofeedback. It seems that in our technologically oriented society, biofeedback training may offer the most effective relaxation training. Part V sums up the book and points out the importance of looking at the whole person and his environment in evaluating his health and to get away from the traditional approach of studying isolated diseases that "just happen" to occur.

ELTON HEATON, M.D.
Madison

MORTAL LESSONS: NOTES ON THE ART OF SURGERY

Richard Selzer, M.D., Simon and Schuster, New York, 1976; 219 pages.

Take a doctor's son, a town-and-gown practice after surgical residency at Yale, plus a late-blooming bent for delicate narrative, add the drive to write before and after working hours, and we have the recipe for beautiful medical essays of a fine distinction such as are found in this volume. Yet Dr. Selzer's writing seems so highly literary that it is difficult to analyze his creativity by component parts. He writes a sort of lyric prose—sometimes straight exposition but, at his best, poetry.

The contents are divided into four large categories begin-

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BOOK REVIEWS

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ning with the art of surgery, next "The Body," "Essays" (miscellaneous) and last straight autobiographical pieces entitled "Down from Troy" (the author was born and bred in that city in New York state). Generally the first works are more engaging for the reader than the last, especially initial dissertation on the "Exact Location of the Soul" and "The Surgeon as Priest." There is a wonderful amount of unusual knowledge for medical practioners in the whole volume and some correlation of anatomy and physiology which gives the reader an overview of various disease states. This is by way of a bonus, for the basic intent seems to be ethical and philosophical exposition. The author treats us to two more extras; he is very humorous and he relates pathos with the verve of a fully emotioned human being. Let it be said, though, he is never maudlin.

What of criticism? Does Richard Selzer tend toward dogmatism? Is he overly singleminded in controversy? The reviewer must aver it is true. He is confident and overconfident in his asseverations. As a urologist, I detected a picayune error regarding his belief in the presence of cilia on the urothelium (there are none).

But why be negative—the author of these essays writes marvelously. Buy this book please—it is a rarely pleasurable read for a doctor.

RODNEY A. MANNION, M.D.
LaPorte

What's New in Books?

Alexander Grant and Company, a CPA firm, has prepared a booklet entitled "The New Hospital Trustee" to acquaint new trustees with the nature and problems of hospital management. The company has served as auditor and consultant for hospitals for 50 years and had assistance from the American Hospital Association in compiling the text. Copies are free. Write to C. Lieberman, c/o the Company, at Prudential Plaza, Chicago 60601.

* * *

Aspen Systems Corporation has announced the publication of THE NEW HEALTH PROFESSIONALS: NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS, a resource document that assesses the present and future of new health practitioners. Written by health care professionals and lawyers. Priced at \$22.00.

* * *

Doubleday has released "Lupus: The Body Against Itself." Authors are Sheldon Paul Blau, M.D., and Dodi Schultz, an award-winning science writer. Dr. Blau is director of the Division of Rheumatic Diseases at Nassau County Medical Center, New York. The book is for public consumption and deals with all the puzzling aspects of systemic lupus erythematosus. 120 pages—\$5.95.

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FUTURE MEETINGS, SEMINARS, COURSES

Academy of Family Physicians Schedules Neonatal Pediatric Workshop in August

A "Neonatal Pediatric Workshop" will be sponsored by the Indiana Academy of Family Physicians at the Brown County Inn, at Nashville on Saturday, Aug. 27 and Sunday, Aug. 28. A full-day program will be presented on both days by large faculty of specialists. The program is acceptable for 14 prescribed hours by the AAFP. Registration for the Workshop is \$125, which includes two lunches and a cocktail party. Write the Indiana Academy at 4847 S. High School Road, Indianapolis 46241 for reservation and hotel reservation form. Families are encouraged to accompany the doctor.

Defibrillation Conference at Purdue

The second Purdue Cardiac Defibrillation Conference will be held Sept. 19-21 at West Lafayette.

Sponsors of the conference are the Purdue Biomedical Engineering Center and the Association for the Advancement of Medical Instrumentation. Tuition is \$120. Contact Gary Lee, Continuing Education Division, Purdue University, West Lafayette 47907.

Announce Pediatric Society Lectureship

The 1977 Thirteenth Annual Louisville Pediatric Society Lectureship will be delivered by Dr. Jay Arena on Nov. 10 at the Health Sciences Center Auditorium, Abraham Flexner Way, Louisville. For information write to Dr. Billy F. Andrews, 200 E. Chestnut St., Louisville 40202.

Workshop on Financing Medical Care

"The Financing of Medical Care" will be the subject of the 10th Annual Workshop of the Institute of Medicine of Chicago, to be held on Nov. 11, from 8 a.m. to 5 p.m. at the

Continental Plaza Hotel, Chicago. Governmental, academic and private insurance company solutions will be discussed. Registration fee is \$45, which includes luncheon and coffee breaks. Write the Institute at 332 S. Michigan Ave., Chicago 60604, or call (312) 663-0040.

Newborn Symposium Scheduled at Louisville

The Eleventh Annual Newborn Symposium of the Department of Pediatrics, University of Louisville School of Medicine, will be held on Nov. 11 and 12. Participants will be Drs. Jay Arena, Frank Oski, George McCracken, William Tooley, Joseph J. Volphe, Phillip Sunshine and Paul Perlstein. For information write to Dr. Billy F. Andrews, 200 E. Chestnut St., Louisville 40202.

Trauma Patient Subject of Course in Ohio

"The Trauma Patient: Care and Complications" is the subject of a continuing education course sponsored jointly by American College of Surgeons and Case Western Reserve Medical School Nov. 14 to 16 at the Marriott Inn, Cleveland. Registration fee is \$200; for residents, interns and nurses \$75. Limited registration. Write Dr. Mark A. Mandel, 2065 Adelbert Road, Cleveland 44106.

Colorado Hospital Offers Winter Courses

Beth Israel Hospital, Denver, conducts a series of continuing medical education courses during the winter. In 1978 courses on Family Practice, Ob/Gyn, Radiology, Psychiatry, Cancer, General Surgery, Internal Medicine and Urology will be held at various times. All are approved for up to 25 hours of AMA Category 1 CME credit. Registration fees are \$190, except in the case of house officers, for whom the fee is \$125. Write for full details: Beth Israel Hospital Conference & Institute Program, 1818 Gaylord St., Denver 80206.



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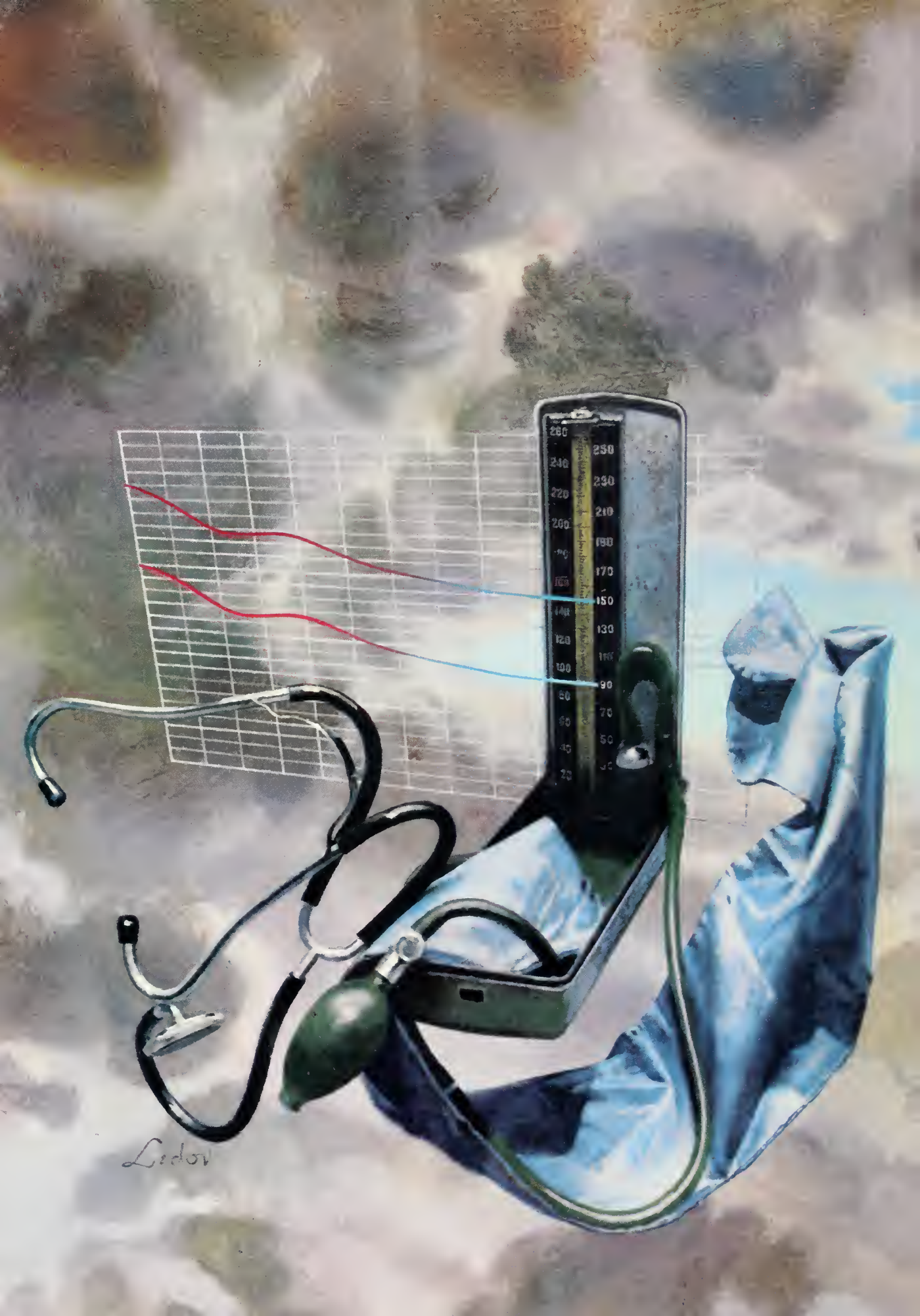
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The investigator noted, "Patient cooperation was surprisingly good for a study of such duration [2½ years]. The once-daily dosage schedule with

metolazone [Zaroxolyn] no doubt contributed to patient compliance."

Overall compliance with Zaroxolyn is good—very good. An analysis of controlled clinical studies involving 188 Zaroxolyn patients showed that only eight discontinued therapy because of side effects. That's a discontinuation rate of only 4.3%, and broader clinical experience appears to substantiate this low rate²

Zaroxolyn. For long-term control and comfortable compliance in mild to moderate hypertension.

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2½-mg, 5-mg and 10-mg tablets

once-daily antihypertensive diuretic

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:**

Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma; allergy or sensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur.

Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing

age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function.

Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur in edematous patients in hot weather. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth,

hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks.

Usual Initial Once-Daily Dosages: mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment may be necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References:

1. Dorfheld L, Kane R: Metolazone in essential hypertension. The long-term clinical efficacy of a new diuretic. *Curr Ther Res* 18: 527-533, 1975.
2. Data on file, Medical Department, Pennwalt Prescription Products



Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester New York 14603



TAX TIPS

LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

If one spouse makes a gift to an individual (other than the donor's spouse) and if the donor's spouse files the appropriate consent for gift tax purposes, then, under the provisions of I.R.C. §2513, the gift may be treated as though one half of it had been made by each spouse.

Prior to the Tax Reform Act of 1976 this gift splitting procedure had three advantages. First, the procedure allowed both spouses to utilize their \$3,000 annual exclusions for gifts of present interests. Second, the procedure allowed both spouses to utilize their \$30,000 lifetime exemptions. Third, the procedure diminished the effect of the progressive gift tax rates by subjecting only half the value of the gift to the rates in each spouse's return, instead of subjecting the entire value of the gift to the gift tax rates, in donor's return.

After the Tax Reform Act of 1976, there still are three advantages of gift-splitting. However, the advantage of utilizing two \$30,000 exemptions is no longer available, because of the repeal of this exemption-deduction. Instead, there now is the possibility of utilizing two unified credits—namely, the fixed gift tax credits of each spouse.

Similarly, prior to the new law there were two disadvantages of gift splitting, namely—(1) that

both spouses became jointly and severally liable for the gift tax, and (2) that the non-donor spouse might utilize that spouse's \$30,000 exemption sooner than that spouse might otherwise want to, in order to minimize the present gift taxes of the donor spouse. Now, because of the replacement of the \$30,000 exemption with the unified credit, the two disadvantages are: the joint and several liability for the gift tax and the possible premature utilization of the unified credit of the non-donor spouse.

Because of the substitution of the unified credit for the \$30,000 exemption and because the unified credit is scheduled to increase (in the amount of approximately \$4,000 per year) for each of the four years which follow 1977, it is going to be much more difficult in the future for lawyers to readily tell clients the amounts which may be given by the clients gift-tax-free from year to year. That is, lawyers will have to memorize (or write on their cuffs) the deduction equivalents for the increasing unified credit, in order to be able to accurately discuss the amount of tax-free gifts which particular clients can make. In addition, such a discussion will have to take into account: the \$3,000 exclusions, the marital deduction, the charitable deduction, any use of the \$30,000 exemption after Sept. 8, 1976, and before Jan. 1, 1977, and the amount of gift taxes paid (or assumed to have been paid) in prior years.

As to the deduction equivalents of the increasing unified credit, these equivalents, on a calendar year basis, are as follows:

Year	Credit	Deduction Equivalent
1977	\$30,000	\$120,667
1978	\$34,000	\$134,000
1979	\$38,000	\$147,333
1980	\$42,500	\$161,563
1981 and thereafter	\$47,000	\$175,625

Thus, assuming that a particular individual had not utilized any portion of the individual's \$30,000 exemption after Sept. 8, 1976 and before Jan. 1, 1977, and assuming

that the individual had not utilized any portion of the individual's unified credit, THEN such an individual could make a gift to an individual other than the donor's spouse, gift-tax-free, during 1977, in the amount of \$123,667. Such a gift would produce a gross gift of \$120,667 (\$123,667—\$3,000); the gift tax on \$120,667 is \$30,000, and this gift tax, less the 1977 unified credit of \$30,000, equals \$—0—.

On the other hand, if this individual was married and the donor's spouse was willing to consent to the splitting of the gift for gift tax purposes, THEN, such an individual could make a gift to an individual other than the donor's spouse, gift-tax-free, during 1977, in the amount of \$247,334. Such a gift, split, would be considered to be a gift of \$123,667 by each spouse (\$247,334 x 50%). And, each spouse could exclude \$3,000, so that gross gifts would be \$120,667, and, as I have pointed out, the gift tax on \$120,667 is \$30,000, which is equal to the 1977 unified credit of \$30,000.

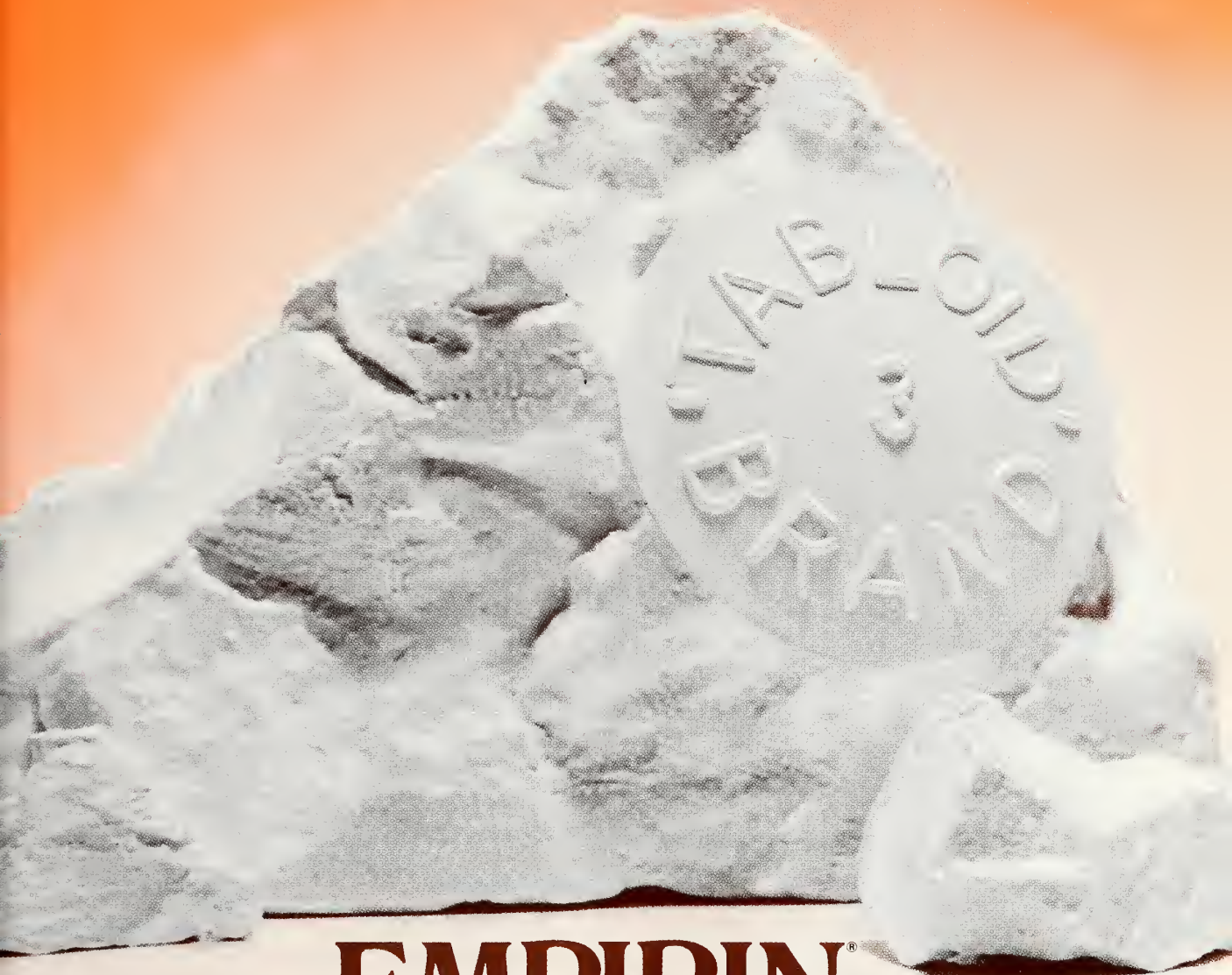
As to the question of the amount of gifts which may be made by a donor to the donor's spouse, this amount is the same as the amount which may be given to a non-spouse (assuming, in the latter case, that the gift is split between spouses and assuming the other facts which are stated above). Thus, under such assumptions a donor may give to the donor's spouse, during 1977, gift tax free, \$247,334. This amount is computed as follows:

Total gift	\$247,334
Exclusion	—3,000
Gross gift	\$244,334
Marital deduction	—123,667
Taxable gift	\$123,667
Gift tax	\$30,000
Unified credit	—30,000
Tax payable	\$—0—


The gift tax marital deduction is

Continued on page 682

**B.W. CO. MAKES CODEINE ANALGESICS.
YOU MAKE THE CHOICE.**



EMPIRIN[®] COMPOUND \bar{c} CODEINE #3

Each tablet contains: codeine phosphate, 32 mg (gr $\frac{1}{2}$), (Warning: May be habit-forming); aspirin, 227 mg; phenacetin, 162 mg; and caffeine, 32 mg. 

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For decades, Empirin Compound \bar{c} Codeine #3 has provided potent analgesia plus the anti-inflammatory action of aspirin for consistently dependable pain relief in the majority of your pain patients. Brand name quality at reasonable cost; readily available in hospital and local pharmacies.

Plus CIII prescribing convenience: up to 5 refills in 6 months (where state law permits), and telephone prescribing permissible in most states. See page 3 of advertisement for prescribing information.

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Introducing the peach-colored
acetaminophen/codeine tablet

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̄ CODEINE #3

Each tablet contains: codeine phosphate, 30 mg (gr ½),
(Warning: May be habit-forming); and acetaminophen, 300 mg. 

Empracet \bar{c} Codeine #3: non-aspirin/codeine pain reliever for aspirin- sensitive patients

EMPRACET \bar{c} Codeine #3 offers you an alternative with advantages for your aspirin-sensitive patients, those with bleeding disorders and "...patients undergoing surgical procedures associated with significant blood loss such as tonsillectomies, open heart surgery, and scoliosis repair..."*

NEW LOOK

Not the same old green and black capsule with a "revised formula." Not a white tablet with aspirin-associations. New peach-colored EMPRACET \bar{c} Codeine #3 looks different from the leading codeine combination products. It doesn't contain aspirin, so it doesn't look like aspirin—imparting greater reassurance to patients leary of taking it by mistake. It also avoids confusion with other tablets in the household.

NEW NAME

Not a household word, the new name may play a positive role in your pain patient's subjective reaction to your prescription.

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*Czapke EE: JAMA 235:636, 1976.

Empracet
 \bar{c} Codeine #3



Empirin Compound
 \bar{c} Codeine #3

EMPIRIN[®] COMPOUND with CODEINE

Contraindications: Hypersensitivity to aspirin, phenacetin, caffeine or codeine.

Warnings: See Warnings below.

Precautions: **Allergic:** Precautions should be taken in administering salicylates to patients with active peptic ulcers and those with known allergies; patients with nasal polyps are especially likely to be hypersensitive to the medication. SEE ADDITIONAL PRECAUTIONS BELOW.

Adverse Reactions: Most frequent adverse reactions are listed below. Some patients taking salicylates develop nausea and vomiting. Hypersensitivity may be manifested by skin rash or anaphylactic reaction. With these exceptions, most side effects occur after repeated administration of large doses; include headache, vertigo, ringing in ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin.

Phenacetin side effects usually result from overdosage. Cyanosis, acute hemolytic anemia, skin lesions, and fever may appear with toxic doses. Continued abuse may lead to renal damage.

Caffeine side effects almost always result from overdosage; include insomnia, restlessness, excitement, tense muscles, and diuresis. Tachycardia and extra systoles may be observed.

EMPRACET[™] with Codeine Phosphate, 30 mg, No. 3

Contraindications: Hypersensitivity to acetaminophen or codeine.

WARNINGS, PRECAUTIONS, ADVERSE REACTIONS AND DRUG INTERACTIONS COMMON TO BOTH PRODUCTS

Warnings: Drug dependence. Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

Usage in ambulatory patients. Caution patients that these products may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

Precautions: Head injury and increased intracranial pressure. Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. These products or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to certain patients such as elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequently include lightheadedness, dizziness, sedation, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; others include: euphoria, dysphoria, constipation and pruritis.

Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.



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Signs Certificate of Ratification
at His Home Without
Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony,
But Both Factions Are

WASHINGTON, Aug. 26, 1920—
The struggle for woman



TRUMAN CLOSES UNITED NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great
Instrument of Peace,'
Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain

Social Security Bill Is Signed Gives Pensions to Aged, Jobless

Roosevelt Approves Message Intended to Benefit 30
Persons When States Adopt Cooperating Laws—Hails
the Measure 'Cornerstone' of His Economic Program

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10,
1971—The Senate approved
today, 94 to 0, and sent to

WASHINGTON, Aug. 26, 1920—
The Social Security Bill, a broad program of unemployment insurance and old age pensions, counted upon to benefit 20,000,000 persons, became law today when it was signed by President Roosevelt in the presence of those chiefly responsible for getting it through Congress.

Mr. Roosevelt called the bill "the cornerstone of my economic program," which is being completed by the Social Security Act, the first step in a program to bring to the aid of the aged, the unemployed, and the disabled.

the Draft Ends No

"If we fail to use it," he declared to the solemn final meeting of the delegates, "we shall betray all of those who have died in order that we might meet here in freedom and safety to create it."

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer: "Oh, what a great day this can be in history!"

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after re-examining a report from the

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA

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Dean Beering Named AMA Section Chairman

Dr. Steven C. Beering, dean of Indiana University School of Medicine, was chosen, at the recent AMA meeting in San Francisco, as the first chairman of the newly established Section on Medical Schools of the AMA. Dr. Beering has been a leader in the movement to give AMA members who are medical school administrators a voice in the development of policies that directly affect their institutions.

Careers Institute Course Accredited

The course for medical assistants offered by Professional Careers Institute, Indianapolis, has been accredited again this year by the American Medical Association committee on accreditation of allied health education programs. The Institute moved last month from its location on East 38th Street to 6321 LaPas Trail, Indianapolis 46268.

Study Hospital Cost Containment Program

Project HOPE, once the sponsor of the peace-time hospital ship S.S. HOPE, and now active in international medical education, has formed a 23-member Committee on Health Policy. The Committee's first project will be the study of the possible consequences of a national program to contain hospital costs. Membership on the Committee will represent the multitude of organizations and interests most closely associated with medical care. More than 80 organizations have been asked to comment. Responses will be integrated with the Committee discussions.

Dr. Besch Heads Pharmacology Department

Dr. Henry R. Besch, Jr., professor of pharmacology and medicine at Indiana University School of Medicine, has been appointed chairman of the Department of Pharmacology and Toxicology, succeeding Dr. James E. Ashmore.

Irradiation-Related Thyroid Cancer Tape Available on Toll-Free Telephone Service

A tape relating to irradiation-related thyroid cancer may be auditioned by physicians by calling a toll-free number of the Dial Access telephone information service. The Access System is operated by The University of Texas M. D. Anderson Hospital. The number to call is 1-800-231-6970. Ask for tape 998.

Neuromuscular Disease Clinic Opens

The Methodist Hospital, Indianapolis, is establishing a Neuromuscular Disease Clinic to serve patients from throughout the state. The clinic is being funded by the Muscular Dystrophy Association, which has been active in the clinic organization. A multidisciplinary approach will be stressed. The clinic will meet in the Children's Pavilion every other Monday from 8 a.m. to noon. Inquiries may be addressed to Richard Weiner, M.D., medical director.

Color Slides, Tapes on Lead Poisoning Explain Need for Rural Lead Screening

A slide show which explains the need for screening patients in rural areas for lead poisoning has been produced under the auspices of the Lead Industries Association and may be obtained on loan for showing to citizen's organizations, clubs and PTAs in rural areas and small towns. The kit consists of 51 35 mm color slides and a cassette tape which contains a message for each slide. Write to the Association at 292 Madison Ave., New York City 10017.

Ayerst Adds Hypertension Booklet

The latest addition to the Ayerst Audiovisual Library Film Collection is "Update: Hypertension," 16 mm color, sound, running time 37 minutes. It deals with treatment of mild, moderate and severe hypertension, including the use of Inderal® (propranolol hydrochloride).

Booklet on Health Care Costs Available

Alexander Grant & Company, a nationwide accounting firm based in Chicago, has published a booklet which examines health care costs. The observations are what should be expected from a CPA, and are interesting. Compared with other countries, the U.S. system is the most expensive as measured by percentage of GNP; it utilizes more physicians and more tests, it uses more support personnel, it uses hospitals more, it reimburses for ambulance rides but not for taxi rides, it pays more for a procedure in a hospital than for the same in an outpatient setting. Many other inconsistencies are listed. Twelve pages of good reading and inferentially good advice. Single copies may be obtained free by writing the company, attention of Claire Lieberman, at Prudential Plaza, Chicago 60601, prices for larger amounts on request.

Hungarian Cancer Society Honors Dr. Weber

Dr. George Weber, Indianapolis, professor and director of the Laboratory for Experimental Oncology, I.U. School of Medicine, has been elected an honorary member of the Hungarian Cancer Society. This is the oldest cancer society in Europe. Dr. Weber is honored for his work on biochemistry of cancer cells. He is the originator of the annual International Symposium on Enzyme Regulation in Normal Tissue and in Cancer, which is invitational and limits invitations to the top 30 researchers in the field. Dr. Weber will receive the diploma of honorary membership in October during the 12th Hungarian Cancer Congress in Debrecen, Hungary.

Breast Cancer Detection Program Inaugurated at Wishard Hospital

The Marion County Cancer Society (Little Red Door) has made a grant of \$65,000 to the Well Women's Center at Wishard Memorial Hospital to establish and maintain a breast cancer detection program. The grant money will finance a special telephone number and will provide an increase of facilities at the Center and will, when indicated, aid in the use of diagnostic x-rays. The program will stress breast examinations, general instructional courses for the public, encouragement and instructions for breast self-examination, physical examinations and, in cases where indicated, mammography and removal of tissue by needle or open method for biopsy. The Center is open to any woman. The fee schedule is the Wishard sliding fee schedule. Patients will be referred to Wishard Memorial Hospital, if eligible and they so desire, or may be referred to their own family physician for treatment.

Schedule for Upcoming NCME Programs

The Network for Continuing Medical Education announces the following schedule of programs:

Aug. 8-Sept. 4 "CHRONIC HEMODIALYSIS: MAXIMIZING THE POTENTIALS," with Eli A. Friedmon, M.D., professor of medicine and director of the Division of Renal Diseases, Downstate Medical Center, Brooklyn, N.Y.

"ASSESSING THE CHILD WITH ACUTE ABDOMINAL PAIN," with Russell S. Asnes, M.D., director, Pediatric Ambulatory Services, and associate professor of Clinical Pediatrics, Columbia Presbyterian Medical Center, New York City.

"THE UNDERGROWN INFANT: AN AMERICAN PROBLEM," with Myron Winick, M.D., director of the Institute for Human Nutrition, the R.R. Williams Professor of Nutrition, and Professor of Pediatrics, Columbia University College of Physicians and Surgeons, New York City.

Sept. 5-Oct. 2 "CLINICAL IMMUNOLOGY UPDATE"—The Mechanisms of Immune Competence;—Immune Deficiency Disorders;—Autoimmune Diseases. The telecourse faculty on this three-part program is Robert M. Nakomuro, M.D., chairman, Department of Pathology, Scripps Clinic Medical Institutions, LaJolla, California, and Ernest S. Tucker, M.D., associate clinical professor of pathology and pediatrics, University of California School of Medicine, San Diego.

Faculty Members Named to Endowed Chairs

Seven outstanding clinical faculty members at the Indiana University School of Medicine have been named to newly-established or re-activated endowed chairs. A fund-raising drive is being instituted to complete the endowment of some of the named chairs. **Dr. James S. Battersby** was appointed to the Willis D. Gatch Professorship of Surgery. **Dr. Robert L. Baehner** was named to the Hugh McK. Landon Professorship of Pediatrics. The William H. and Sallie E. Coleman Professorship of Gynecology and Surgery was awarded to **Dr. Charles A. Hunter**. **Dr. Suzanne B. Knoebel** received the Herman B. and Elnora D. Krannert Professorship of Medicine. The Albert Eugene Sterne Professorship of Clinical Psychiatry was awarded to **Dr. Hugh C. Hendrie**. **Dr. Walter J. Daly** was named the John B. Hickam Professor of Medicine.

Three other professors currently hold endowed chairs. They are **Dr. Robert J. Rohn**, the Bruce Kenneth Wiseman Chair of Medicine; **Dr. David M. Gibson**, the Showalter Chair of Biochemistry, and **Dr. Morris Green**, the Perry W. Lesh Chair of Pediatrics.

Errata

THE JOURNAL regrets that the listing in the June issue of the following Indiana hospitals did not include the two asterisks before the name that indicate that they are "Medicare Approved":

Jennings Community Hospital, North Vernon
Terre Haute Regional Hospital, Terre Haute
Warrick Hospital, Inc., Boonville
Wishard Memorial Hospital, Indianapolis

The two Fort Wayne Ambulatory Surgical Centers—Fairfield Surgical Center and Fort Wayne Surgical Center, Inc.—are also "Medicare Approved," according to the State Board of Health.

Fellowships in Diabetes Research Offered

The Juvenile Diabetes Foundation announces the availability of postdoctoral fellowships in diabetes research for the funding year July 1, 1978, to June 30, 1979. Applications, which are to be postmarked no later than Sept. 10, 1977, may be obtained by writing Grant Administrator, 23 E. 26th St., New York City 10010, or by calling (212) 689-7868.

OSMA Offers Booklets Giving Consumer Views

The Ohio State Medical Association has published two reports concerning the medical malpractice problem. The Association commissioned a survey of attitudes of consumers in 1976. The results of the survey are the basis for the two publications. "Consumer Attitudes Toward Health Care and Medical Malpractice" contains the full report and is designed for use by physicians and other health care professionals. "Consumers Speak About Health Care" is a summary of the highlights of the report and is geared toward the general public. The Association, 600 S. High St., Columbus 43215, is selling the reports at the rate of \$9.95 plus 50 cents postage and handling for the large volume and \$2.50 plus 50 cents postage and handling for the smaller.

Sandoz Announces Contest Results

Medical Journalism Awards by Sandoz Pharmaceuticals are announced for 1977. First-prize recipients are *Virginia Medical*, the journal of the Medical Society of Virginia, and the *Nebraska Medical Journal*. Honorable mention went to *Texas Medicine* and the *Journal of the Mississippi State Medical Association*. Besides state medical journals, Sandoz recognized, by similar awards, several county medical bulletins, publications of pharmaceutical associations and bulletins of medical clinics.

New I.U. Hospitals Administrator Named

Roger S. Hunt, associate vice-president and hospital administrator at the Hahnemann Medical College and Hospital of Philadelphia since 1974, was named director of the Indiana University Hospitals recently. Mr. Hunt, a native of New York state, received an A.B. degree from DePauw and the degree of master of business administration in health care administration from George Washington University. ◀

OCTOBER						
SUN	MON	TUE	WED	THU	FRI	SAT
<small>SEPTEMBER</small> <small>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30</small>	<small>SEPTEMBER</small> <small>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30</small>			<small>LAST QUARTER</small> <small>24h</small>	<small>BEST QUARTER</small> <small>10h</small>	1
2	3	4	5	6	7	8
9	10 <small>Columbus Day</small>	11	12 <small>Traditional Columbus Day</small>	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
ISMA 1977 ANNUAL MEETING Hyatt Regency Hotel • Indianapolis						
30	31	NINETEEN SEVENTY-SEVEN				

computed by adding the marital deduction base of \$100,000 to 50% of: the total gifts to the spouse which are in excess of \$200,000—namely, 50% of \$47,334, which is \$23,667.

My final observation about gift splitting, as far as this article is concerned, is of considerable im-

portance—namely, that the election to split gifts will not (itself) prevent the *entire* value of the property from being included in the donor's gross estate (under I.R.C. §2035) in the event that the donor dies within three years after the date on which the gift is made. That is, under prior law split gifts

could have been fully includable in the donor's gross estate as gifts in contemplation of death, and under the new law gifts (split or not) will automatically be includable in the donor's gross estate if the donor dies within the three-year period (or if one of the other "gross estate" sections is applicable). ◀

About Our Cover

The Wabash College Chapel, constructed in 1928 as a memorial to the pioneers of Indiana, is used for regular worship and convocations.

Founded in 1832 at Crawfordsville by five ministers and four laymen, Wabash now has a 50-acre campus that contains 32 buildings. It is a private, independent, undergraduate liberal arts college for men. The traditional liberal arts curriculum is balanced with special programs for pre-professional students. All graduates receive the bachelor of arts degree. More than 450 Wabash alumni are physicians and surgeons.

One of the few colleges in the nation that neither seeks nor accepts federal funds, Wabash is supported by voluntary gifts which provide one of the highest endowments per student in the nation. It has an endowment of approximately \$40 million. Wabash has an extensive program of financial aid and attempts to assist all applicants who demonstrate financial need as well as others who achieve academic excellence in high school. Special awards and scholarships include the Lilly Awards, Honor Scholarships and President's Scholarships.

Dr. Jack W. Hickman, a 1955 graduate of the Indiana University School of Medicine and former faculty member, who is presently associate dean of the University of South Florida College of Medicine, Tampa, is a member of the Board of Trustees of Wabash College.

(Seventh in a series featuring the independent colleges and universities of Indiana.)

From THE JOURNAL 50 Years Ago

Does the gall bladder first become infected, later spreading to the liver, or is the process reversed; the primary infection occurring in the liver and later spreading to the gall bladder?

To Graham of Washington University belongs the credit for first calling attention in 1918 to the almost universal association of hepatitis with cholecystitis. This fact has been verified by many investigators since. . . .

In Graham's original paper printed in 1918, after presenting his evidence that hepatitis is a constant accompaniment of cholecystitis, he makes the very natural enquiry—"Is the cholecystitis primary or secondary to hepatitis, or are the two conditions concomitant in origin?"

Four years later, after experimental work and clinical observation, he answers the question with the statement that gall bladder infections are, in the majority of cases, lymphatic infections carried over from a previously infected liver; the liver infection occurring by way of the portal circulation, from which origin the gall bladder is infected by way of the lymphatics.

This conception of the sequence of events in the development of gall bladder disease is now pretty generally accepted and forms a much more rational basis for therapy, either surgical or medical, than the embolic theory emphasized by Rosenow. . . . "Liver Pathology and Physiology and Its Relation to Diseases of the Gall Bladder," by Murray N. Hadley, M.D., Indianapolis, JISMA, August 1927.

Deaths

Thomas D. Armstrong, M.D.

Dr. Thomas D. Armstrong, 69, general surgeon and obstetrician, died at his home in Michigan City June 13.

He earned his M.D. degree from Rush Medical College of the University of Chicago in 1932 and began his practice in Michigan City in 1937 following five years of private practice elsewhere. He interned at St. Louis City Hospital and the Mayo Clinic.

A Fellow of the American and also the International College of Surgeons, Dr. Armstrong was a past president of the LaPorte County Medical Society and of the Northern Tri-State Medical Association. He served for a number of years on the Commission on Public Information and as secretary of the commission in 1964. He served for many years as a delegate from LaPorte County.

During World War II Dr. Armstrong served as medical director of the county Civil Defense unit.

Dr. Armstrong was also a member of the American Medical Association.

Robert L. Brown, M.D.

Dr. Robert Louis Brown, Evansville, died May 14. He was 57.

A graduate of the Indiana University School of Medicine with the Class of 1944, Dr. Brown had been in general practice in Evansville since 1946.

He was a member of the Vanderburgh County Medical Society and the American Medical Association.

Joseph W. Gibbs, M.D.

Dr. Joseph W. Gibbs, 71, Danville, died June 7 at home.

A 1925 graduate of Northwestern

University Medical School, Dr. Gibbs interned at Norwegian American Hospital, Chicago, following which he practiced at Danville until 1952.

In 1952 Dr. Gibbs took the position of medical director at the Home Lawn Mineral Springs sanitarium, Martinsville, and, following its closing about 1970, maintained a private practice at Martinsville and Danville until 1974, when he retired.

He was a member of the American Medical Association and the Hendricks County Medical Society.

J. Winford Mather, M.D.

Dr. J. Winford Mather, Lake Station (formerly known as East Gary) family practitioner, died May 6. He was 78.

He practiced in Lake County for 39 years, following his 1936 graduation from Rush Medical College, and was on the medical staff of the Methodist Hospital of Gary and Our Lady of Mercy Hospital, Dyer.

Dr. Mather was a member of the Lake County Medical Society and the American Medical Association and served as a delegate from his county society to the Annual Meeting of the Indiana State Medical Association in 1962, 1963 and 1964.

In 1970 Dr. Mather became a Senior Member of the Indiana State Medical Association.

James S. McElroy, M.D.

Dr. James Stewart McElroy, New Castle, died June 17 in a nursing home. He was 70.

Upon his graduation from the Indiana University School of Medicine in 1934, Dr. McElroy was a resident in surgery at the I.U. Medical Center, fol-

lowing which he commenced his practice of general surgery at New Castle in 1939.

A member of the American College of Surgeons, Dr. McElroy was a veteran of World War II.

In 1967 he served as president of the Henry County Medical Society; he was also a member of the American Medical Association.

Okla W. Sicks, M.D.

Dr. Okla Wilbur Sicks, Indianapolis surgeon for 50 years, died June 9 in a nursing home. He was 84.

Admitted to practice medicine in Indiana in 1920, following his graduation from the Indiana University School of Medicine, Dr. Sicks was active in the Marion County Medical Society and the Indiana State Medical Association, serving as treasurer of the Student Loan Committee and as a member of the Commission on Governmental Medical Services for many years.

Dr. Sicks was state medical director of the Indiana Vocational Rehabilitation Department in 1962.

In World War II, Dr. Sicks was chief of surgery for the 308th General Hospital on the Pacific island of Tinian in the Marianas. He also was chief of surgery at Garner General Hospital in Chicago and at Camp Pickett in Virginia and attained the rank of colonel.

He served as president of the medical staff of St. Vincent Hospital in 1941 and again in 1952. He also was on the faculty of the I.U. School of Medicine and was a member of the American College of Surgeons and of the American Medical Association, attaining senior membership status in 1964. In 1970 he became a member of the ISMA 50-Year Club.

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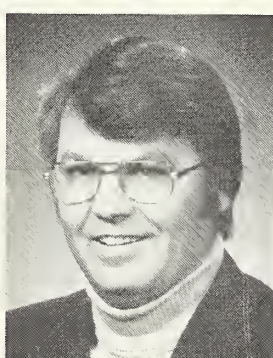
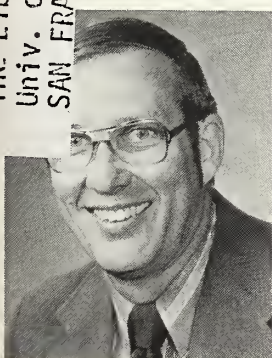
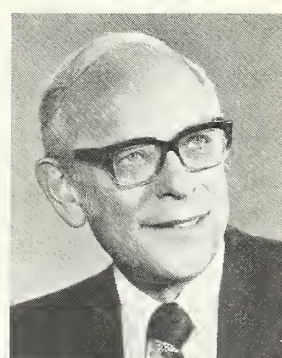
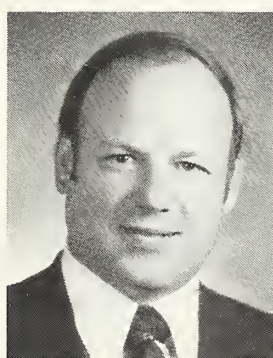
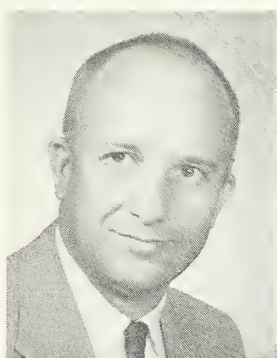
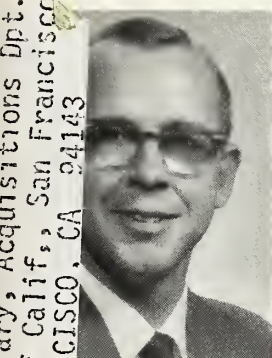
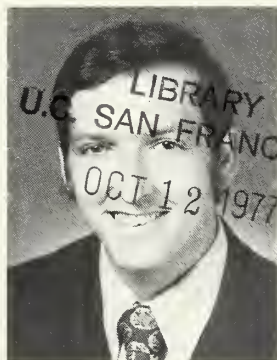
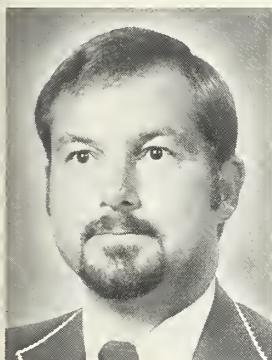
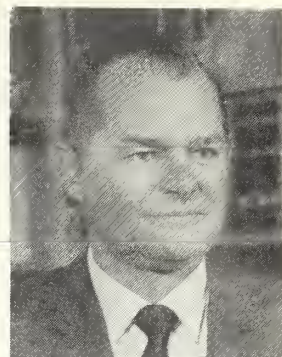
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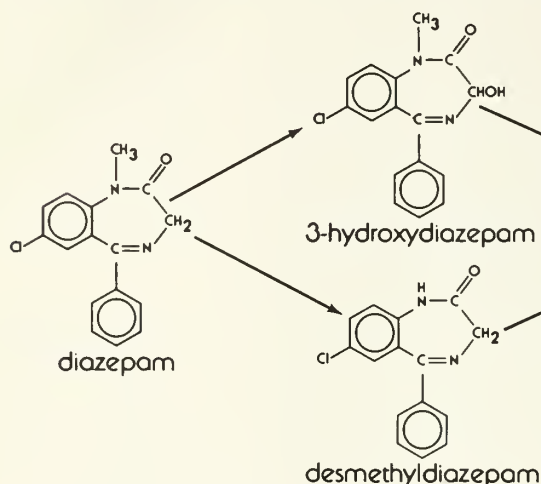
Warnings: Not of value in psychotic patients.

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MEDICAL MUSEUM NOTES



The current issue of the *Indiana Medical History Quarterly** is concerned with the caricature of the medical school teacher. The Museum has a number of photographs of caricatures of teachers at the old Central College of Physicians and Surgeons, and at the Medical College of Indiana, some of whom became faculty members of Indiana University School of Medicine after the union of the schools in 1908. Among others, these include Drs. Frank Wynn, Tom Eastman, and Alembert Brayton. The current issue of the *Quarterly* reproduces the

*Published by the Indiana Historical Society, 315 W. Ohio St., Indianapolis 46204.



DR. CHARLES MCCORMICK. Professor of obstetrics for many years, Dr. McCormick was noted for his use of rectal ether as anesthetic of choice for delivery.



DR. GEORGE BOND. A pioneer in the science of electrocardiography at Johns Hopkins, he first introduced the subject to Indiana University School of Medicine.

caricatures (along with portraits) of a few of these early teachers. These include Drs. Larue Carter, John Oliver, Theodore Potter, Edmund Clark, Edward Hodges and Albert E. Sterne, Dr. Sterne, the state's first neurosurgeon, was a student of Charcot and of Victor Hoarsley.

The Museum recently received an original set of caricatures done by medical student artist Terrence Billings. Dr. Billings, a 1936 graduate of the Indiana University School of



DR. EDWIN KIME, associated with different departments, but known always for anatomy and for asking difficult anatomical questions.



DR. THURMAN RICE, professor and chairman of the Department of Bacteriology and Public Health. Also Medical Historian of the school and the state in the 1930s and 40s.

Medicine, now lives in Atlanta, Ga. His caricatures will be more familiar to many *Journal* readers than the earlier ones mentioned above. The primary purpose of the present page is to show examples of Billings' artistry. Although these were done in the 1930s, the physicians shown here were still teaching at least into the 1950s. Many readers will have pleasant memories evoked by these caricatures.

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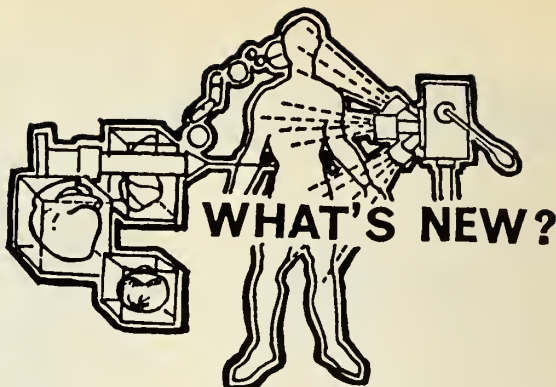
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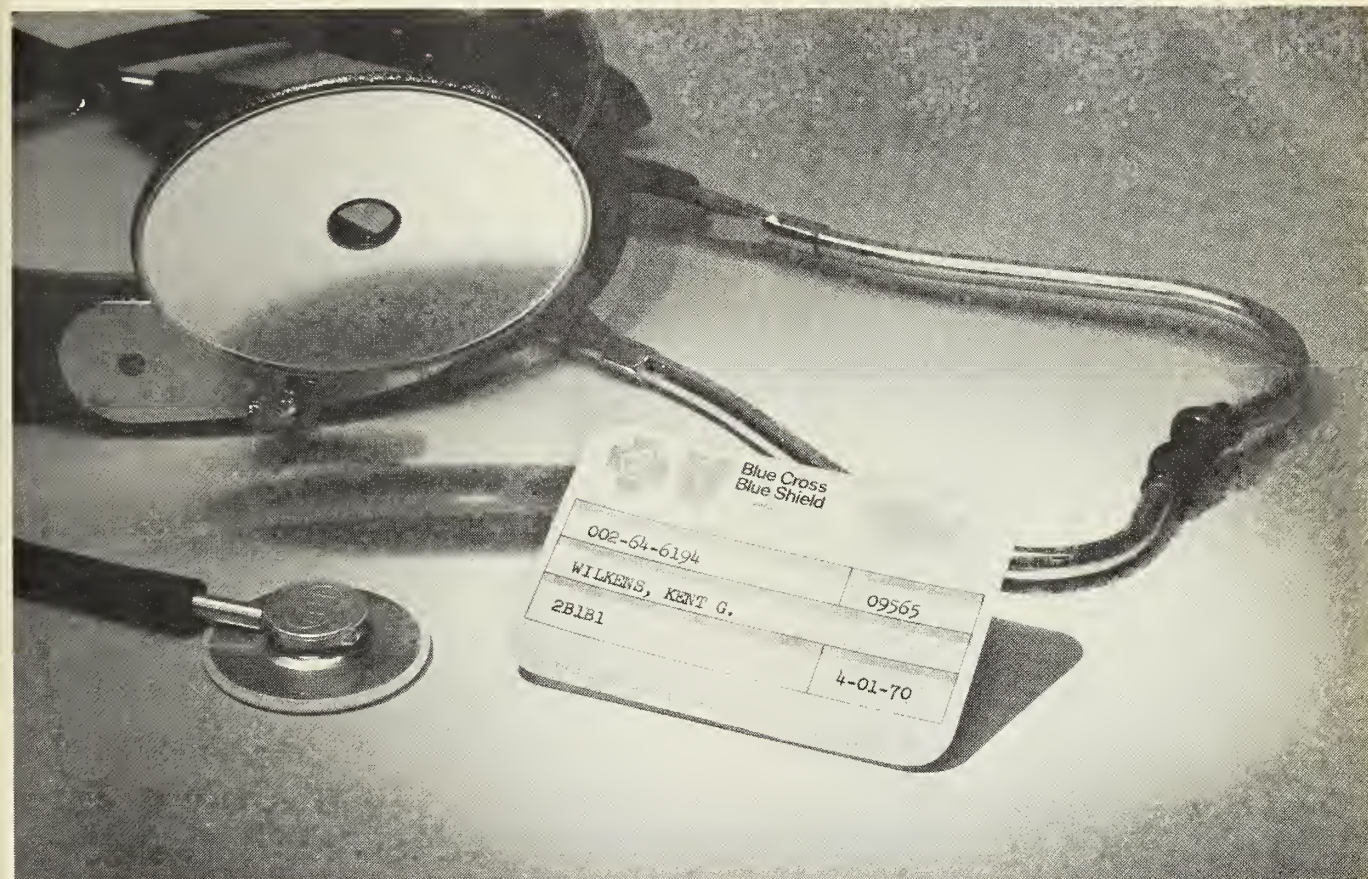
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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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MONTH IN WASHINGTON

STRONG PRESSURE FROM PRESIDENT CARTER and other Administration officials and a desire by Congress to get some handle on rising health care costs appear to be weakening Congress' previously firm sentiment against the Administration's Hospital Cost Containment program. Some Hill observers now believe the plan—in some form or other—is picking up enough momentum to clear Congress this year, a possibility viewed as remote earlier in the session.

The Cost Containment plan calls for imposition of an annual ceiling of about 9% on all hospital revenue increases. It places a \$2.5 billion limit on capital expenditures. Major health provider groups, including the American Hospital Association and the American Medical Association, have assailed the plan as a revival of the discredited wage and price freeze of several years ago.

A BILL BEFORE THE CONGRESS would mandate that prescription drug packages would carry a warning label stating:

Warning to physicians and patients—the federal Food, Drug and Cosmetic and Devices Administration approves this drug or device for the following purposes and no other purpose.

Drugs would be accompanied by patient package inserts approved by the FDA explaining in layman's language the uses of the drug, a description of the side effects and so on.

This provision of a sweeping drug measure proposed by Sen. Edward Kennedy (D-Mass.) was attacked by the AMA. "By setting out in bold print and by directing the warning to physicians and patients, the statement raises a spectre that a drug as prescribed is dangerous," said Lowell H. Steen, M.D., Hammond, Ind., a member of the AMA's Board of Trustees. "We believe that such a phrase unduly intrudes into the practice of medicine in an attempt to limit in some manner the use of a drug," said Dr. Steen.

"To mandate a drug label warning that in any way suggests that a drug can, because of special federal approval, be used properly for only certain conditions and not for any other condition is an improper attempt to restrict the necessary freedom of the physician to prescribe the needed treatment," Dr. Steen said.

Dr. Steen noted that the AMA supports certain additions to the drug labeling requirements and has drafted a bill that would require certain information to be listed on the drug container dispensed to the patient.

But, he told Kennedy's Health Subcommittee, "it is highly inappropriate to include a requirement that the proposed warning be placed on all drug labels. Moreover, we believe that all drugs should not be required to have patient package inserts. The preparation and distribution of the information to be required in the patient package inserts pose a number of problems. Patients differ in their drug requirements with respect to dose, duration of therapy and adjunct medication.

This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

They also differ in therapeutic response, adverse side effects and toxic reactions. 'Patient package insert' might be helpful to some patients, but might confuse, frighten or even harm other patients."

The most appropriate source for a patient desiring drug information is the physician. The AMA official testified "we do not believe that it is desirable for the Commissioner of FDA to publish mini-treatises on drug usage for dissemination to patients for all drugs. A professional judgment on what is the best treatment for the patient is the physician's responsibility and is made on the basis of extensive training and experience."

Dr. Steen spoke favorably of a Kennedy provision for an expanded drug-testing program for drugs that have not yet received new-drug application approval. This, he said, "could be highly beneficial in bringing new drugs and chemical entities to the market as expeditiously as possible. There have been indications that our present system of new-drug approval has led to a relative drug lag between the United States and other industrialized countries."

MUCH OF THE AUTONOMY AND POWER of the 10 HEW regional offices have been eliminated in a major reorganization by HEW Secretary Joseph Califano.

Powers once vested in the regional directors were shifted to HEW headquarters in Washington, D.C., bringing to dust the goal of the Nixon Administration to establish "mini-HEWs" with substantial independence to deal with regional problems. However, the 10 offices with tens of thousands of employees across the nation will stay in business, but with much closer ties to the nation's capital.

THE AMA IS SUPPORTING A BILL to increase Veterans Administration physician and dentist pay.

The legislation before the Senate would extend for one year authorization (Pay Comparability Act of 1975) for the administrator of the Veterans Administration to provide special pay to eligible physicians and dentists. The bill also provides that a physician or dentist who has entered into an agreement with the Veterans Administration which will be completed during the extended authorization period may enter into a new agreement not to exceed four years in duration.

In a letter to the Senate Committee on Veterans Affairs, James H. Sammons, M.D., AMA executive vice president, said:

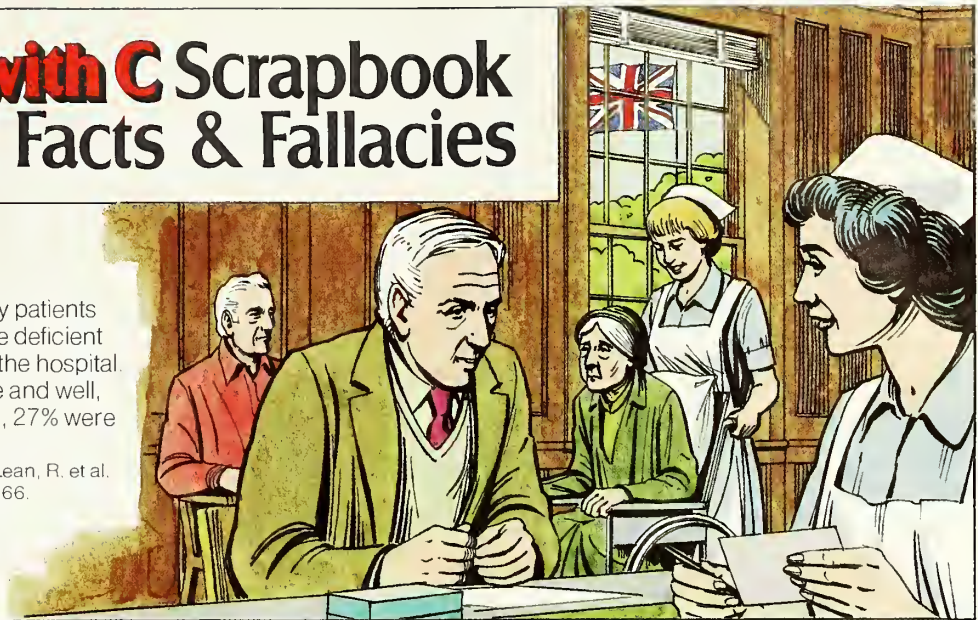
"The American Medical Association has been supportive for many years of the federal government's efforts to recruit and retain career-minded health professionals for federal health delivery programs."

"We urge that the Congress act favorably on this legislation to assure the continuation of current authorities to provide more adequate and equitable compensation for physicians and dentists in the Veterans Administration health care system," said Dr. Sammons. ◀

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Griffiths, L.L., Brocklehurst, J.C., MacLean, R. et al. *Diet in Old Age*, Brit. Med. J., 1:739, 1966.



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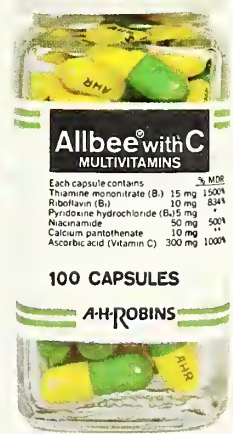
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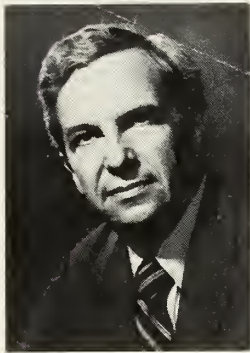
Phenobarbital	($\frac{1}{4}$ gr) 16.2 mg (warning: may be habit forming)	($\frac{1}{2}$ gr) 32.4 mg
Hyoscyamine sulfate	0.1037 mg	0.1037 mg
Atropine sulfate	0.0194 mg	0.0194 mg
Hyoscine hydrobromide	0.0065 mg	0.0065 mg

Indications: Based on a review of this drug by the NAS/NRC and/or other information, FDA has classified the following indications as possibly effective: adjunctive therapy in the treatment of peptic ulcer; the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Brief summary. Contraindicated in patients with glaucoma, renal or hepatic disease, obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy) or a hypersensitivity to any of the ingredients. Blurred vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur at higher dosage levels, rarely at the usual dosage.

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Report of the President



I am taking the liberty of using the "President's Page" to briefly present to you the actions, or the lack of action, on items which I enumerated to you earlier. On reflecting over the last 11 months, I have mixed emotions about the issues presented to the House of Delegates in my Inaugural Address. In some areas I feel that the Association has made great progress, but in others we have not moved, or at least not moved far enough. Some of the subjects before you for consideration are:

1. **Arbitration**—it was my opinion that the time had come to consider arbitrating reasonable reimbursement for our medical services, and the House of Delegates concurred in adopting amended substitute Resolution 76-4 which dealt with the current structure of medical care financing. The resolution suggested systems for providing such equitable treatment with the following options: a) statewide collective bargaining; b) formation of a state medical foundation for medical care; c) the ISMA to act as a party to insurance negotiations, and d) adoption of insurance payment plans in substitution for "usual and customary . . ."

As president of the Association I appointed an Ad Hoc Committee on Arbitration to carry out the mandate of the House. A detailed report of this committee will be before the House of Delegates in October 1977. The report emphasizes the need for studying the area of negotiation more thoroughly and points out the extensive training seminars being conducted throughout the country by the AMA Department of Negotiations. The report also recommends that a permanent Committee on Negotiations be established by the ISMA and, this being vital, I hope that it will be approved.

2. **Policing Our Own**—As a profession, we must be responsible for those doctors among us who are ill from mental disease, alcoholism or drug abuse. Therefore, an Ad Hoc Committee on the Impaired Physician was appointed, and it has met four times as of this writing. The Committee has investigated programs initiated in other states and is in the process of developing a program for Indiana physicians in co-operation with the Medical Licensing Board. The Committee plans to use the guidelines provided in the Medical Practice Act.

The program, as outlined by the Committee, will consist of, but not be restricted to, an informal and formal referral of impaired physicians, list of treatment and referral resources, county medical society screening committees, and an examining committee.

The Committee has formulated its recommendations into a resolution which would also make the Committee on the Impaired Physician a standing committee of this Association, and it is my hope that this is also accepted.

3. **Cost of Health and Medical Care**—This is one area in which I feel little or no progress has been shown; however, I am encouraged by plans which the Commission on Public Relations is developing.

At the time of our last meeting a special committee was directed to investigate and organize a seminar on Health Care Costs. The seminar would include representatives from business, politics, medicine and the news media.

I have also appointed an Ad Hoc Committee on the CAT Scanner to investigate the proliferation of the scanner, in addition to its cost, both of which problems concern me considerably. Part of the Ad Hoc Committee's investigation has revealed that the initial cost of the scanner is being reduced; more important is the fact that examinations formerly used for the diagnosis of head diseases are being discontinued or have been reduced significantly by the use of the CAT.

The real dilemma, however, is whether the Certificate of Need legislation should apply to physicians' private offices as well as to hospitals, in order to control the

Continued

unregulated acquisition of costly apparatus. Perhaps it is time to declare a moratorium on additional CAT scanners until some more definitive criteria can be established. To that end, I would strongly urge, with Dr. Goodman's approval, that the Ad Hoc Committee on CAT Scanners be continued until these problems can be resolved.

4. **Blue Cross/Blue Shield**—It has been stated that all too often Blue Shield policy is formulated by full-time staff without direction or approval by the Board of Directors, and it is my opinion that we need to insure that the input of the ISMA is more substantial.

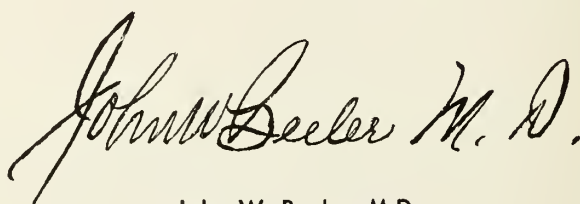
About a quarter of our members have contracted for health insurance through our state association, and we now have a specific representative to contact for information or for the handling of complaints. We are also trying to determine the number of members of our Association who have individual group policies with BC/BS, but who are not covered under the state plan. This, I am sure, will amount to a significant number of ISMA members and, therefore, we can expect improvements in the handling of the claims service and we can watch the total utilization and cost.

5. **Legislation**—No one could have foreseen all the problems which arose during the year, the most emotional of which was the legislation on Laetrile. This bill created a particular quandary since most of us object to its use. Secondly, because of the inherent conflict in the state of Indiana, as it relates to the federal law, there is a question as to the ISMA legally advising a physician to violate any law, since a potential for federal criminal prosecution exists which cannot be ignored. Finally, for a physician to prescribe the substance he must know the dosage to give, and, without quality control, the potential liability will eventually fall upon the physician.

This leads me to another problem which confronts your incoming president and officers—namely, the lack of firm policy, as dictated by the House of Delegates, on issues critical to medicine, in order that your president and officers can honestly express the reflection of its members. Our positions on PSRO, Certificate of Need, compulsory CME, are primary examples of the need for a firm authoritative voice. It seems to me that the problems of medicine should be brought to the House of Delegates by controversial resolutions and debated so that a policy can be formulated which represents the consensus of our Association.

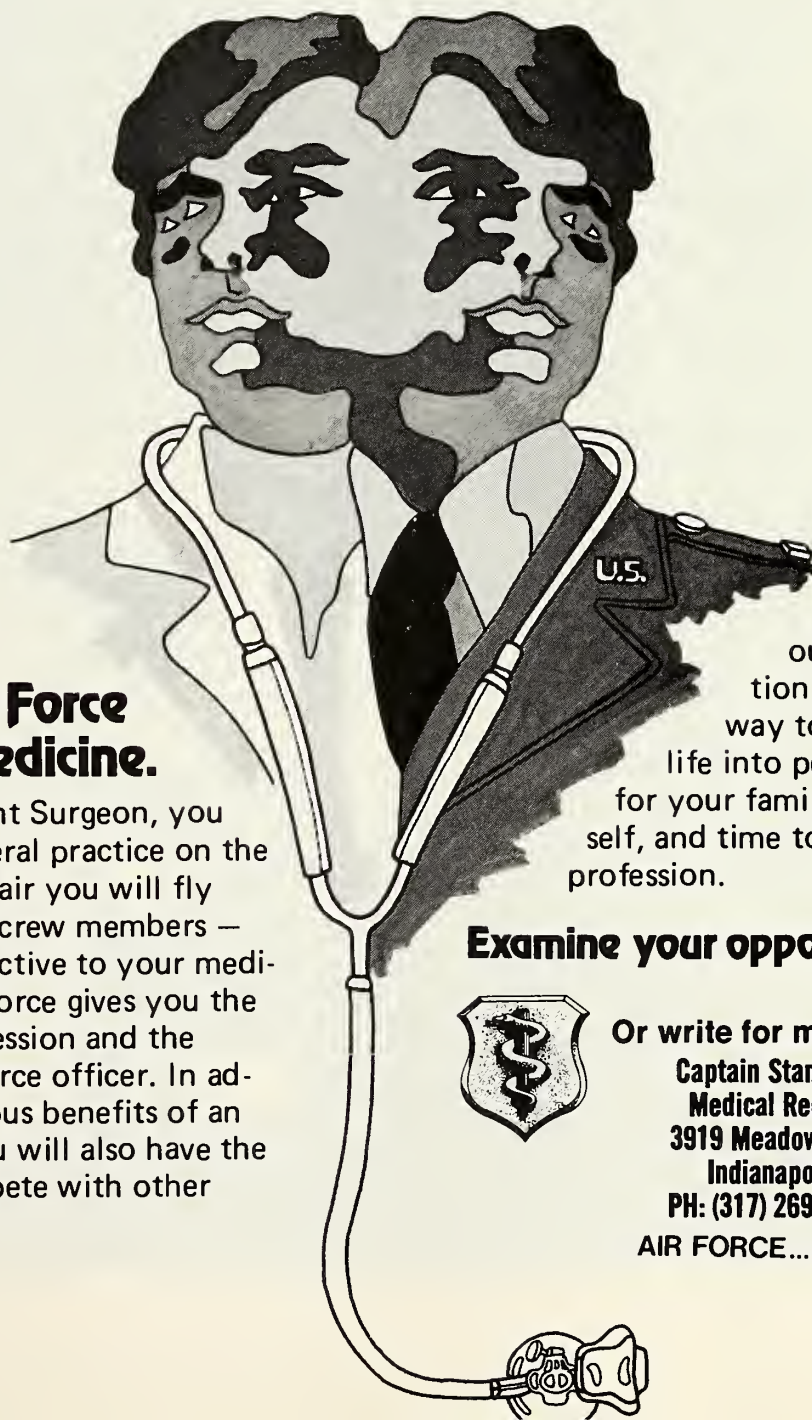
The last area of my concern was the increasing encroachment of hospitals on the private practice of medicine. Secretary Califano's constant repetition that there is no competition in medicine or between hospitals is negated by the fact that hospital outpatient departments get larger and larger, physicians as full-time salaried employees of hospitals are increasing at an alarming rate, and satellite hospitals with hospital-owned laboratories and x-ray facilities are in ever-increasing competition with private practitioners. In these times, hospitals and physicians must learn to help each other, but not at the expense of eliminating private practice.

This House of Delegates has always meant very much to me, for it is here that medicine's problems can be aired and argued, so that all the physicians of the state, having been adequately represented, can establish a united position in response to all the many problems which the government is foisting upon us today. My thanks to all of you for giving me this opportunity to serve you, and to those many of you who have supported me so patiently. God bless you.



John W. Beeler, M.D.
President
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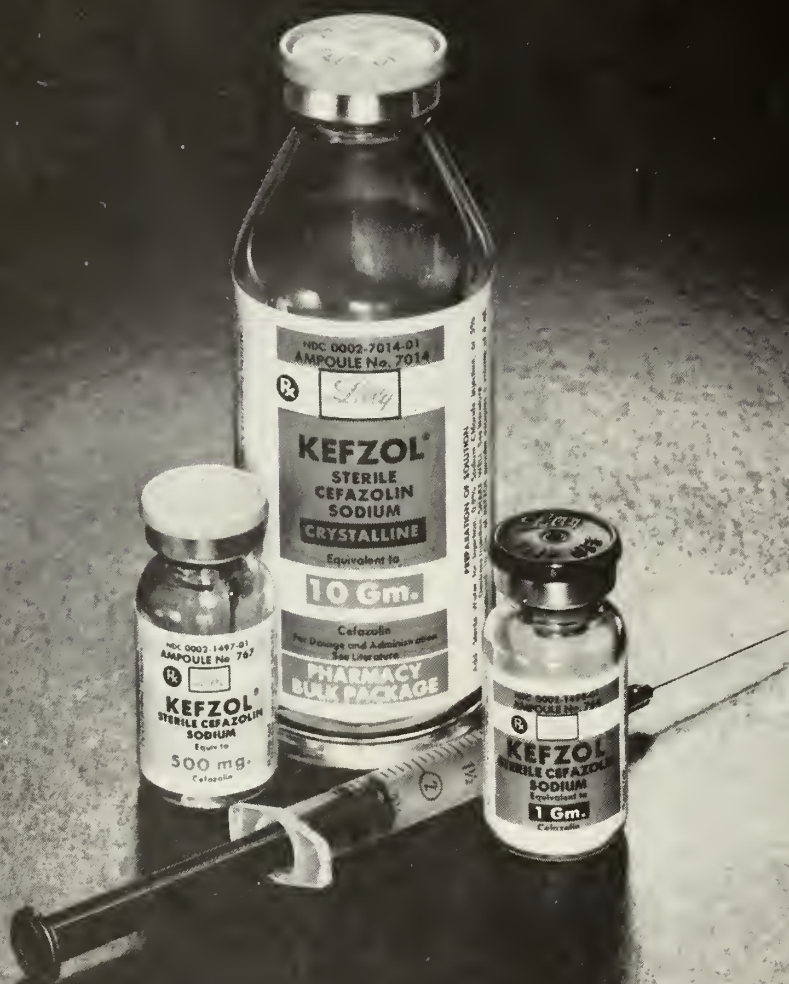
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*Medicine Grand Rounds—Indiana University
School of Medicine*

Extracted from the Grand Rounds presentation of
Nov. 10, 1976, to the faculty, house officers and
students of the Department of Medicine, Indiana
University School of Medicine.

Systemic Lupus Erythematosus

KENNETH D. BRANDT, M.D.

MARLENE A. ALDO-BENSON, M.D.

Indianapolis

Dr. Brandt:

WE would like to begin by describing some of the clinical aspects of systemic lupus erythematosus (SLE), with emphasis on certain features of the illness. We will also discuss some of the newer knowledge concerning immunopathogenesis of SLE and, finally, some aspects of management of the patient with this disease.

SLE is a multi-system disease par excellence and may be responsible for virtually any clinical abnormality. (Table 1) Prior to the availability of supporting laboratory tests, such as the LE prep and the antinuclear antibody test, which have facilitated the diagnosis of SLE in patients with early and/or mild disease, clinical descriptions emerged chiefly from patients who had obvious and, often, severe illness. The

diagnosis was then rather restricted to a subset of patients, i.e., typically, young females, usually with very severe disease, who often had a tell-tale rash.

The classical rash of SLE is an erythematous blush in the butterfly distribution. Lupus rashes may occur in any area of the skin, however, such as over the elbows or on the forearms. A minority of patients with SLE and skin involvement have the rash of discoid lupus—either on the face or in other areas. Alopecia may occur and may heal with scarring. The skin changes of SLE are very common, but may be very subtle. Sometimes one sees only a transitory blush or a little erythema on the fingertips or the eyelids.

The organ system most commonly involved in SLE is the musculoskeletal system. Patients frequently present with slight soft tissue swelling of proximal interphalangeal or metacarpophalangeal joints. Commonly, the arthritis of SLE is no

more marked than this. Indeed, while articular complaints occur in some 90% of patients with SLE, many exhibit no objective evidence of synovitis, but merely complain of arthralgias or stiffness of the joints.

TABLE 1. COMMONEST CLINICAL MANIFESTATIONS IN SYSTEMIC LUPUS ERYTHEMATOSUS.

MANIFESTATION	% INCIDENCE
Arthritis and Arthralgia	91.6
Fever	83.6
LE Cells	75.7
Skin Changes	71.5
Adenopathy	58.6
Anemia (<11 GMS)	56.5
Anorexia, Nausea, Vomit	53.2
Dysproteinemia	53.0
Myalgia	48.2
Renal Changes	46.1
Pleuritis	45.0
Leukopenia	42.6
Pericarditis	30.5
Pleural Effusions	30.3
Central Nervous System	25.5

From the Rheumatology Division, Department of Medicine, Indiana University School of Medicine, Indianapolis.

Publication made possible by a grant from Eli Lilly and Company.

It is relatively uncommon in SLE to observe the marked synovial proliferation and gross joint effusions that one may see, e.g., in the patient with rheumatoid arthritis. Histologically, in SLE one sees a low grade synovitis with collections of chronic inflammatory cells in the synovial membrane. In further contrast to rheumatoid arthritis, the joint disease of SLE is seldom erosive. Destruction of articular cartilage and subchondral bone due to pannus formation is rare. Soft tissue lesions, however, such as ulnar deviation of the fingers, and metacarpophalangeal joint subluxation, may develop.

Some patients with SLE have joint pains because of aseptic necrosis, which may occur as a complication of steroid therapy, but certainly occurs also in individuals with SLE who never received steroids. Aseptic necrosis in SLE is most common in the hip, shoulder and knee, but may occur in virtually any joint. The pathogenesis of the lesion is not well understood. Quite commonly in SLE, as in other connective tissue diseases, myalgias occur. Occasionally, one sees definite evidence of myositis, with elevations of the muscle enzymes.

Underlying many of the protean manifestations of SLE a systemic vasculitis may often be demonstrated. Cytooid bodies in the eye, which are infarcts in the nerve fiber layer of the retina, are one representation of this vasculitis. They look like cotton wool exudates and are not specific in their appearance, but their development in a patient with SLE strongly indicates activity of the disease. We have been impressed by the strong correlation between the finding of cytooid bodies and clinical evidence of central nervous system lupus. We should emphasize that this form of retinal vasculitis usually does not impair vision and is not associated with eye pain. Because cytooid bodies may be transient, it is important to perform frequent ophthalmoscopic examinations on the patient with SLE.

While one usually considers seizures, stroke and psychosis as the

major manifestations of central nervous system lupus, we have been struck by the relatively high prevalence of less dramatic central nervous system abnormalities in lupus. Indeed, lupus involvement of the central nervous system may account for virtually any clinical neurologic feature. We have been confronted by a high prevalence (10-15%) of sensory postchiasmal neuroophthalmic manifestations, e.g., scotomas, homonymous hemianopias, cortical blindness and visual hallucinations. We have also seen the development of migrainous symptoms in about 10% of our patients with SLE, and they appear to have a vascular basis. In some patients headaches may be the most disabling feature of the disease. Migrainous symptoms in SLE may be precipitated by solar exposure, and they will often flare and recede in parallel with other clinical manifestations of the disease. Furthermore, in some cases they may be more effectively controlled by corticosteroids than by usual anti-migrainous drugs.

Often, when we talk to patients and families about SLE, it is the renal manifestations, above all else, which factor into our thinking with respect to prognosis and survival. It is important to point out, however, that one cannot view lupus nephritis generically. Rather, there are different types of lupus renal disease. For example, diffuse proliferative glomerulonephritis is a lesion that carries a poor prognosis. Only about 25% of patients with this lesion are alive five years after the onset of their renal disease. On the other hand, focal proliferative glomerulonephritis is a much less severe disease and carries with it a much more favorable prognosis. While focal glomerulonephritis may, in some cases, progress to diffuse nephritis, this is not the case in the vast majority of patients and the focal lesion tends to remain focal throughout the lifetime of the individual. A third form of lupus nephritis is membranous glomerulonephritis. In this lesion one sees thickening and wire-looping of the

glomerular capillaries. Diffuse membranous glomerulonephritis in lupus carries a prognosis intermediate between focal and diffuse proliferative disease.

While one can often make a reasonable guess as to the type of renal lesion present on the basis of the abnormalities seen in renal function and in the renal sediment, prediction of the renal histology on the basis of clinical or laboratory studies is not uniformly possible. This provides a justification for renal biopsy in such patients, since one must consider what kind of lupus nephritis one is dealing with as he counsels the patient about prognosis and considers whether to treat the renal disease with potentially life-threatening drugs.

Finally, we should mention that in some patients with SLE specific organ-system involvement may not be present, but the individual may be severely ill, nonetheless, with a syndrome of "toxemia." Such patients have high fever, anorexia and weight loss as the predominant features of their illness. Some have a rapidly downhill course with marked cachexia and hectic fevers. In such patients, the disease activity may be dramatically reversed by corticosteroid therapy.

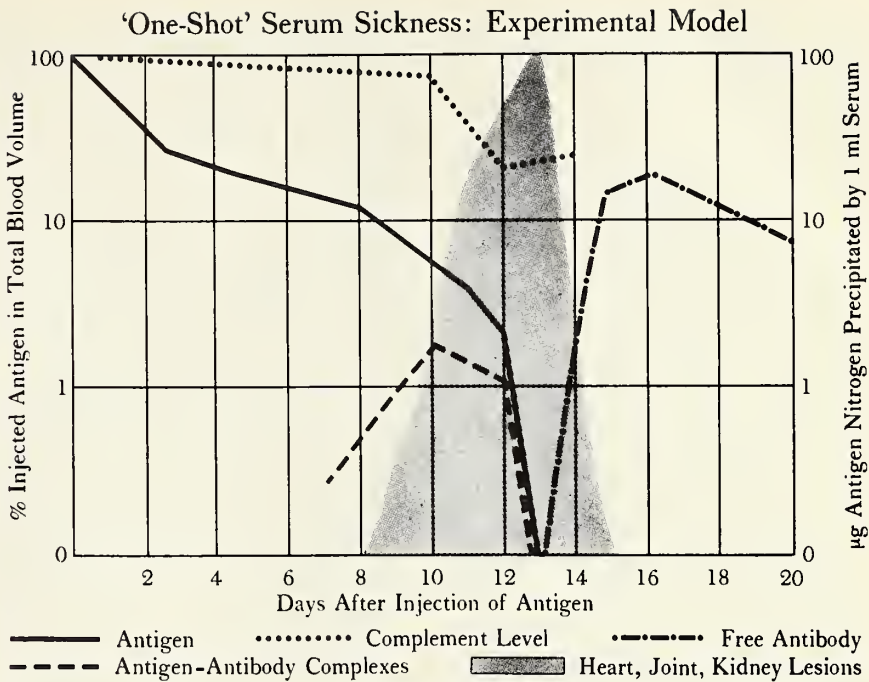
Dr. Aldo-Benson:

As physicians, we're all interested in the clinical manifestations and presentation of SLE which Dr. Brandt has just discussed. However, an understanding of the immunologic mechanisms and pathogenesis of the disease may help us to understand why there is such wide variation in clinical manifestations and why so many organ systems are affected. Most of the pathological changes and tissue damage which we see in SLE are due to autoantibodies. These may cause tissue damage by two separate mechanisms: (1) Tissue may be damaged *indirectly* by immune complexes which may be deposited within it—the "innocent bystander" basis for immune complex disease. This mechanism operates also in other diseases such as serum sickness. (2) Autoantibodies may also cause

direct tissue injury, i.e., cytotoxic antibodies in SLE may be directed against tissue antigens. We're going to discuss both mechanisms of immunologic damage today, and their role in the pathogenesis of SLE.

Immune complex disease was originally studied using the experimental model of serum sickness. (Fig. 1) The experimental animal in this model is usually a rabbit. The disease is induced by injecting the animal intravenously with a soluble antigen, e.g., bovine serum albumin (BSA). On about the fifth or sixth day after injection the animal begins to produce antibodies which combine with the BSA antigen, causing a decrease in the amount of circulating BSA antigen and an increase in circulating antigen-antibody complexes. At the same time that immune complexes begin to appear in the serum they also deposit in tissues, causing damage, e.g., to heart, joints and kidneys. The shaded area in Figure 1 shows the incidence of these tissue lesions. At the same time that tissue damage occurs the serum complement levels decrease. Once the antigen-antibody complexes are cleared, the involved tissues begin to heal and the disease resolves itself within three or four days. By studying this model and other animal models, mechanisms of immune complex disease have been fairly well worked out.

Figure 2 illustrates the mechanisms by which immune complexes cause tissue damage. In serum sickness and other immune complex



The sequence of events in classic "one-shot" serum sickness parallels the record of an experiment involving injection of I¹³¹-labeled bovine serum albumin into a rabbit. As detectable antigen-antibody complexes appear in the circulation, complement drops to less than half normal values, morphologic lesions appear in heart, blood vessels, joints, kidneys. Shortly after all antigen-antibody complexes are eliminated, free antibody appears in circulation, and inflammatory lesions rapidly disappear.

FIGURE 1

diseases circulating antibody is formed against foreign antigens. In SLE, however, the antibody is directed against self-antigens. The immune complexes formed by antigen-antibody interaction have the capacity to induce platelet aggregation causing a release of vasoactive amines, with a consequent increase in vascular permeability. The in-

crease in the vascular permeability facilitates tissue deposition of the immune complex, which then fixes complement. As a result of the activation of the complement system, chemotactic factors are generated, which lead to an influx of cells into the tissue. Two factors in this reaction determine whether or not tissue injury occurs:

I M M U N E C O M P L E X D I S E A S E

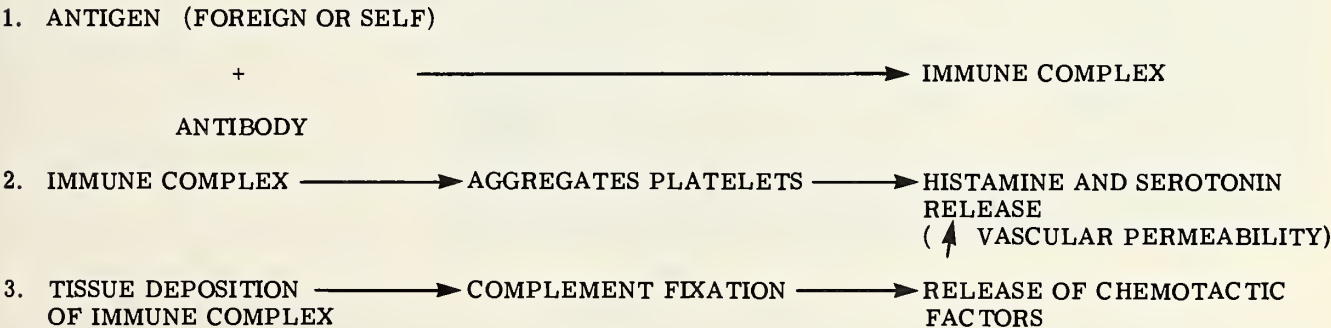


FIGURE 2

The first is the size of the immune complex. The second is complement fixation. If the immune complexes are very large (as they are when there is a large antibody excess) they tend to be cleared by the reticuloendothelial system and thus are not deposited in the tissue. On the other hand, if the immune complexes are very small (as in antigen excess) they remain soluble and do not deposit in the tissue, and, again, do not cause disease. However, at approximate equivalence of antigen and antibody, immune complexes will deposit in the tissue and cause disease.

The other important factor in pathogenesis of immune complex disease is complement fixation. IgM antibodies and certain sub-classes of IgG antibodies readily fix complement and cause tissue injury. However, other sub-classes of IgG, such as IgG-4, do not fix complement and thus do not have the ca-

capacity to induce tissue injury by this mechanism. This may explain why SLE is mild in some patients and severe in others, and why only about 50% of lupus patients have nephritis.

Figure 3 is a diagrammatic representation of the mechanisms by which nephritis may develop in SLE. Circulating anti-DNA complexes with DNA and complement, is deposited in glomerular basement membrane and passes through basement membrane to the subepithelial region. Complement fixation causes a release of complement components, which are chemotactic factors, which attract polymorphonuclear leukocytes to the glomerular basement membrane. These cells release enzymes and basic proteins which cause tissue damage. Recently, some studies have suggested that DNA may bind to the glomerular basement membrane, not as an im-

mune complex but before the anti-DNA antibody is attached to it. Studies in vitro have shown that DNA itself has very high affinity for basement membrane collagen, whereas DNA-anti-DNA complexes do not. DNA which is attached to glomerular basement membrane will still bind readily with anti-DNA, fix complement and lead to the subsequent events producing tissue damage mentioned above.

Figure 4 shows fluorescent antibody staining of a glomerulus in lupus nephritis. The granular appearance of the deposits along the basement membrane represents the deposition of immune complexes. This kidney is stained with fluorescent anti-human IgG. The same pattern would be seen if it were stained with antibody against DNA or antibody against complement.

Studies of immune complexes eluted from the kidneys in SLE

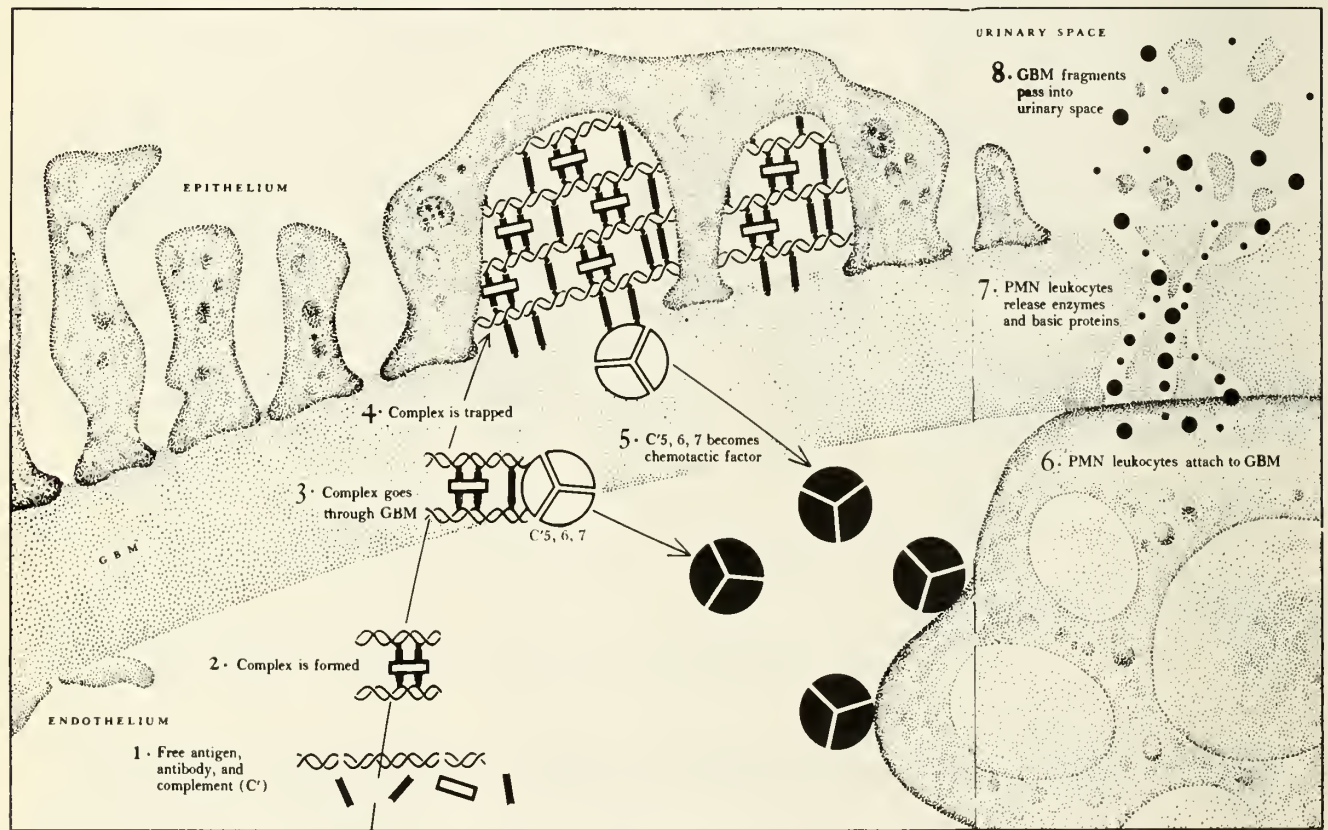


FIGURE 3

In the glomerular injury of systemic lupus erythematosus, the circulating antigen may be DNA, which complexes with circulating antibodies and complement. The complexes pass through the GBM and are trapped between the membrane and the epithelial cells; C'5-6-7 is transformed into chemotactic factor. This attracts PMN leukocytes, which become attached to GBM. Pratealytic enzymes and basic protein complexes are then released. These "chew up" the

have shown that the antibodies which are deposited have specificities against a variety of antigens. The most frequently discussed are the anti-DNA antibodies, but there are also antibodies against RNA protein, nucleoprotein, histones and cytoplasmic antigens. The antigens which have been found in these complexes include DNA and antigens from the C-type RNA virus. Still other antigens may be present in the glomerular immune complexes but for technical reasons they have not yet been demonstrated. Of course complement which is necessary for the tissue damage, as we've described, is also readily eluted from the lupus kidney.

Immune complex deposition occurs not only in the kidney but also in other tissues in SLE. Complexes have been demonstrated in blood vessels of the spleen and probably account for the typical onion-skin appearance and the vascular proliferative lesion in that organ. Complexes also have been demonstrated in the choroid plexus of the brain. It's unclear what role they may play in central nervous system disease in lupus. Immune complexes have not been demonstrated in other blood vessels of the brain. Indeed, there is usually no sign of acute vasculitis in the brain of patients with clinical evidence of central nervous system lupus. Whether immune complexes are a major factor or just one of the minor factors involved in the central nervous system lupus is unknown. Immune complexes are deposited also in the skin in SLE at the dermal-epidermal junction and may account for many of the cutaneous lesions. They provide the basis for the "band test" which some workers have felt is a very good diagnostic test for SLE. Immune complexes are deposited in the synovial membrane and probably account for many of the articular symptoms which Dr. Brandt mentioned.

The other mechanism of tissue injury in SLE, which we mentioned earlier, is direct cytotoxicity. Numerous autoantibodies are formed in SLE, many of which have specificity

for tissues or for circulating cells. These antibodies may combine directly with these tissues, fix complement and cause either cell lysis or tissue damage through the same complement pathway that we have discussed. Severe clinical manifestations of SLE are accounted for by direct cytotoxic injury. Coomb's-positive hemolytic anemia is due to an anti-erythrocyte antibody. Anti-leukocyte antibodies are found in probably about 70% to 80% of patients with SLE. Only about 40% of these patients, however, have leukopenia. It may be that those patients who do not have leukopenia produce a sub-class of anti-leukocyte antibody which does not fix complement. Anti-platelet antibodies are also found in a high percentage of patients with SLE, and account for thrombocytopenia. However, not all patients with anti-platelet antibodies have thrombocytopenia. The anti-clotting factors in SLE are the circulating anticoagulants, which uncommonly cause a bleeding diathesis syndrome. Anti-thy-

roid antibody is also found in a small percentage of patients and probably accounts for thyroiditis seen in 1% or 2% of patients with lupus.

Autoantibodies are thus central to the pathogenesis of SLE. The cause of autoantibody production is still unknown, but a great deal of experimental data has been compiled which permits a reasonable hypothesis. It is known that antibody production in man is regulated by thymus-derived lymphocytes (T cells). These may either augment or suppress antibody production. Abnormalities in these T cells have been demonstrated in SLE, and it is quite likely that the suppressor function of these cells is lost, permitting antibody production against self-antigens, to which man is usually tolerant. Some investigators feel that C-type RNA viruses may be responsible for the loss of T cell function. The role of viruses in SLE, however, is still open to question.

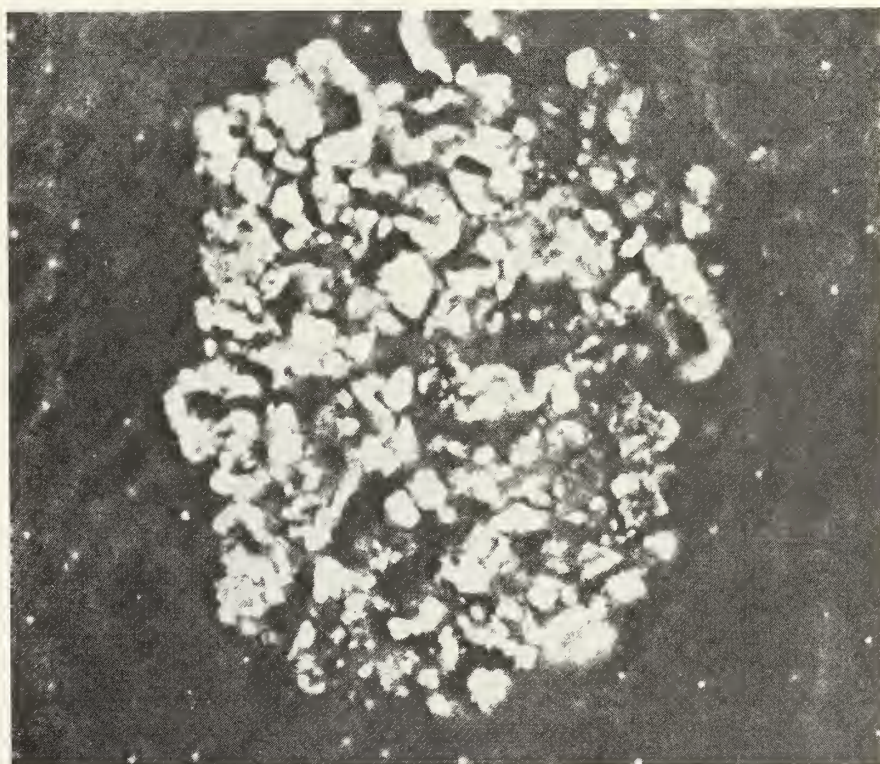


FIGURE 4

A glomerulus from a patient with diffuse proliferative SLE which has been stained with fluorescein-labeled anti-human IgG. Note the granular appearance of the stain which denotes deposition of immune complexes along the glomerular basement membrane.

TABLE 2. DRUG TREATMENT OF SLE

DRUG	INDICATIONS
Salicylates	Arthritis and Arthralgia Myalgias Fever Fatigue Pleurisy Rash (mild)
Hydroxychloroquin (Plaquenil)	Discoid lupus Rash (severe) Arthritis
Corticosteroids	Glomerulonephritis Renal failure CNS lupus Carditis Fever unresponsive to ASA Hemolytic anemia Thrombocytopenia Severe leukopenia Uveitis

Finally, we would like to touch briefly on drug treatment of SLE. Therapy in SLE should be tailored to the patient. A positive laboratory test alone does not require treatment. Similarly, symptoms and a positive ANA or LE cell test may not need therapy (indeed, 2% or 3% of normal individuals may have low titers of antinuclear antibody).

The drugs used to treat symptomatic patients should depend on the clinical manifestations of disease.

(Table 2) Anti-inflammatory doses of salicylates (12 or more aspirin per day, sufficient to achieve a serum salicylate level of 20-25 mg%) may reduce, or completely ameliorate, the rash and musculoskeletal symptoms and the constitutional symptoms of fatigue and fever. Thus, if a patient has only these disease manifestations, salicylates should be given a therapeutic trial of two to three months which, if effective, will preclude the need

for more toxic drugs.

Plaquenil (hydroxychloroquin), 200 mg per day, may be used at the outset in patients who have significant facial rash or discoid lupus, and is quite effective. It may also be added to full doses of aspirin in patients who have had only partial response of their arthritis and skin rash with that agent. These two drugs in combination may be more effective than either alone.

In our opinion, systemic corticosteroid therapy should be reserved for patients with severe or life-threatening manifestations of SLE. (Table 2) We prefer to institute therapy with high doses of steroids, which are then tapered when disease activity is suppressed. In every case it is important to evaluate disease activity at each follow-up visit, and to arrive at a therapeutic decision as to whether the dose of steroids may be lowered.

Immunosuppressive drugs, such as azathioprine or cyclophosphamide, in our view, should still be considered as experimental in treatment of SLE, and should be given only for severe disease, under circumstances of meticulous follow-up and with the informed consent of the patient.

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The Patient with Hypertension: A Scheme for Management

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Indianapolis

IT is simple and inexpensive to evaluate and treat the majority of patients with hypertension. Actually, unlike many diseases in the setting of "modern medicine," the hypertensive work-up has become less cumbersome and we now eliminate some studies previously considered routine. This article will outline an approach to the usual patient who presents with high blood pressure.

Who Should be Treated

Nobody knows for sure to what level the blood pressure must rise for it to be hypertension and thus a risk to the patient. What appear to be reasonable criteria are those proposed by The Hypertension Study Groups of the Inter-Society Commission for Heart Disease Resources, which are the following: (1) under 40 years of age, a blood pressure greater than 140 mm Hg systolic and/or 90 mm Hg diastolic, (2) 40 years of age and older, 160 mm Hg systolic and/or 95 mm Hg diastolic, and (3) children less than 14 years of age, blood pressure approaching 140/90 mm Hg. The elevated blood pressures must be observed on at least two of three successive determinations on different days. It should be noted that the systolic pressure is as important as the diastolic in predicting those patients who should be treated. Even in the elderly patient where one may find purely systolic hyperten-

sion, in most cases this pressure should be reduced. The presence of other risk factors for cardiovascular disease warrant a more aggressive approach to treatment of any increase in blood pressure.

Evaluation of the Hypertensive Patient

Primarily, we look for (1) evidence that the hypertension may have caused injury to the heart, kidneys or vasculature, (2) other risk factors for cardiovascular disease, and (3) data that suggest that the patient does not have essential hypertension but rather a "secondary" and sometimes curable form of hypertension. The examination of the patient begins with a good routine history and physical exam with some particular points of emphasis added.

History. Important historical data are time of onset of hypertension,

history of heart disease, renal disease, renal trauma, renal stones, use of birth control pills or other estrogens, hypertension during pregnancy, diabetes, excess alcohol consumption, smoking of cigarettes, licorice ingestion, edema, symptoms of exertional chest or leg pain, shortness of breath, orthopnea, muscle weakness, paresthesias, nocturia, headache, paroxysmal palpitations, sweating and flushing. A family history of hypertension, cardiovascular disease and/or diabetes is critical information.

Physical exam. The blood pressure is recorded in both supine and standing positions, and most physicians now use the 5th Korotkoff phase (disappearance of sounds) to indicate diastole. Size and function of the heart and status of peripheral vessels require careful assessment. The optic fundi reveal the severity of the hypertension by the extent of arteriolar constriction, a physical finding which is relatively easy to gauge. Arteriolar sclerosis (increased light reflex and A-V nicking) reflects chronicity, but it is not specific for hypertension and is more difficult to quantitate. Flame-shaped hemorrhages, "cotton-wool" exudates, and papilledema indicate accelerated or malignant hypertension which requires prompt intervention. Deserving special mention is auscultation of the epigastric area for the presence of an abdominal bruit. This must be carried out assiduously for it to have its rewards. If a systolic bruit extends into diastole, this is strong evidence for



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the presence of a stenotic renal artery. A mass in the area of the kidney may be a polycystic kidney, or a renal or adrenal tumor. Finally, are there features to suggest Cushing's syndrome?—does the patient have café au lait spots or neurofibromas and harbor a pheochromocytoma?

Laboratory and x-ray studies. For the majority of hypertensive patients it is sufficient to obtain a hemogram, urinalysis, serum potassium, serum creatinine and/or BUN, fasting blood sugar; in patients less than 60 years of age a serum cholesterol and fasting triglycerides, chest x-ray and electrocardiogram. To properly evaluate the serum potassium, patients must have discontinued diuretics, including spironolactone and triamterene, two to three weeks earlier. We do not routinely obtain a hypertensive intravenous pyelogram or measure urinary excretion of catecholamine metabolites.

The above evaluation is extended to look for surgically remediable forms of hypertension if (1) the patient is young (less than 35-40 years of age), (2) medical management has failed to provide blood pressure control or (3) there are definite signs to suggest a secondary form of hypertension. Of the latter, the most commonly pursued clues are an abdominal bruit, recent onset of hypertension, and/or malignant hypertension (renovascular disease), a low serum potassium (primary aldosteronism) and paroxysmal symptoms (pheochromocytoma).

Treatment

We use a step-up approach, a regimented scheme of adding more medication until the blood pressure is controlled. The initial drug is a diuretic, the second a sympatholytic (propranolol, methyldopa, cloni-

dine or reserpine), and the third a direct vasodilator (hydralazine). We prefer propranolol over other sympatholytic agents since it appears to provide an effective antihypertensive response with fewer side effects; even at high doses propranolol is frequently tolerated well. The antihypertensive pharmacology of propranolol is unique; it lowers renin, decreases cardiac output and inhibits centrally outflow from the sympathetic nervous system. Propranolol is contraindicated in patients with asthma, heart failure and diabetes treated with insulin; and, like its sympatholytic counterparts, can produce impotence. In most cases both propranolol and hydralazine need be administered only once every 12 hours; thus, a schedule easy for the patient to follow can be arranged.

In our clinic we start with hydrochlorothiazide 50 mg daily (or its diuretic equivalent) and then increase to 50 mg twice daily. If further reduction in blood pressure is required, we give propranolol at a dose of 20 mg every 12 hours; if more drug is needed, the dose is increased to 80 mg, then 160 mg daily. At this point and possibly earlier, we would start hydralazine 25 mg every 12 hours, increasing to 100 mg and then 200 mg daily. We usually do not exceed a total daily dose of propranolol of 480 mg or a dose of hydralazine 300 mg daily. The reflex tachycardia produced by hydralazine is counteracted by the beta-blockade effect of propranolol, and the combination of these two drugs with a diuretic is effective in treating 75% of patients with mild to moderate hypertension (diastolic pressures <120). Changes in medication are made at intervals of one week to one month, and patients are seen frequently during this period while the proper drug regimen is being developed. Obviously, there are other acceptable

combinations of antihypertensive drugs and these will be discussed in a review of the pharmacology and uses of antihypertensive medications to appear in a subsequent issue.

Patients must have their serum potassium and blood sugar measured within a month of starting treatment with a thiazide diuretic. With hypokalemia one can give supplemental potassium (40-80 mEq/day) or use a potassium-sparing diuretic. Frequently one must resort to the latter. Severe hypokalemia suggests primary aldosteronism. Repeat potassium measurements should be made at six-month intervals. In the mild or latent diabetic who develops clinically important hyperglycemia while using thiazides, we often prefer to treat with insulin than to deprive a hypertensive patient of the effects of a diuretic. It should be noted that the potassium-sparing diuretics appear to be no less diabetogenic.

A patient's knowledge of hypertension may improve compliance, and as a part of the education process we recommend he read *The Silent Disease*, an excellent book by Lawrence Galton, available in paperback for \$1.75. Most of our patients measure their own blood pressure at home, which not only allows us to better assess control, but involves the patient in the management of his disease, a factor which may be one of the most important in improving patient compliance.

Summary

A careful history and physical examination and several inexpensive laboratory tests are sufficient to evaluate most patients with hypertension. An effective antihypertensive drug regimen for many patients is either a diuretic alone, a diuretic — propranolol combination, or a diuretic — propranolol — hydralazine combination. ◀



SEMINARS FROM RILEY CHILDREN'S HOSPITAL

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A Practical Guide to Pediatric Electrocardiography— Part Two

Rate and Rhythm

RATE and speed of conduction have great variability, being both age and activity dependent.¹ (Table 3) It is interesting that the newborn's rate may be near 100 during the first few days of life, and then increases, not dropping back to 100 until 4-5 years of age. When diagnosing "tachycardia" this age dependency must be considered. Stress influences rate; 1°F temperature elevation usually raises the pulse 10-15 beats. The most profound effect of any arrhythmia is the resultant effect on heart rate and the degree of myocardial irritability producing ventricular arrhythmia.

Tachycardia

A mild tachycardia may be normal or even beneficial, since an increase in cardiac output results. Tachycardia may be a compensatory mechanism for congestive heart failure. However, at rates more than twice normal, diastolic filling is impaired and output may decrease. Paroxysmal supraventricular tachycardia (PST) is perhaps the most common of the serious ar-

rhythmias encountered in pediatrics. PST is often found in patients with structurally normal hearts; in such patients symptoms of irritability or "palpitations" may occur, with congestive heart failure often a late (48 hours or more) manifestation. These patients have rates up to 300. Usually p waves are aberrant or merge with T waves. The ventricles usually respond to each supraventricular impulse with a normal QRS contour. Most attacks of PST may be converted with digitalis; other therapeutic approaches include vagal stimulation, neosynephrine, propranolol or counter shock. Overall, the prognosis is good for a patient with PST.

Bradycardia

Bradycardia may occur normally in response to vagal stimulation, during sleep, or be present in those with "athlete's heart." Sinus bradycardia is associated with increased intracranial pressure, jaundice, hypothyroidism and drugs (notably, digitalis). Usually, atrioventricular heart block (AVB) is the most serious form of bradycardia, especially when there is complete or 3° AVB. At extremely slow rates (< 80 in infants, < 50 in older children) symptoms of dizziness or syncope (Stokes-Adams) attacks may occur. Congestive heart failure may also develop. Symptoms relate to the inadequate output, presum-

TABLE 3. HEART RATE AT VARIOUS AGES

(Beats per Minute)

Age	Minimum	Mean	Maximum	SD*
0-24 hours	85	119	145	16.1
1-7 days	100	133	175	22.3
8-30 days	115	163	190	19.9
1-3 months	115	154	205	18.6
3-6 months	115	140	205	21.0
6-12 months	115	140	175	18.7
1-3 years	100	126	190	19.8
3-5 years	55	98	145	18.0
5-8 years	70	96	145	16.1
8-12 years	55	79	115	15.0
12-16 years	55	75	115	13.5

*SD—standard deviation

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Part One appeared in August, pages 659-661.

ably affecting coronary and cerebral vessels most significantly. Myocardial irritability may result in multiple extraneous ventricular responses and eventual ventricular fibrillation. The EKG shows regularly beating ventricles, dissociated from the more rapid atrial complexes. It is sometimes thought that if the block be proximal to the His bundle, the QRS will have a normal contour and duration, while slurred QRS complexes suggest a distal block. In those with "congenital" block and normal morphology, prognosis is quite good, since only about 25% of such patients become symptomatic. However, those with symptoms, especially patients with acquired AVB, require emergency treatment, usually with temporary and permanent pacemaker therapy.

Irregular Rhythm

Sinus arrhythmia, a very common occurrence in children, usually has cyclic variation, often corresponding to the respiratory cycle. Though it may mimic an irregular rhythm, it is benign and requires no treatment.

Premature ventricular contractions (PVCs) are the most common ectopic rhythm in children. These do result in an irregular rhythm, suggesting "skipped beats." EKG shows an early bizarre, widened QRS complex, usually fol-

lowed by a compensatory pause and a normal beat. This is usually a benign condition, since in most children with otherwise normal hearts the PVCs lessen during exercise and eventually disappear spontaneously. When PVCs occur in clusters of three or more, the arrhythmia is then termed ventricular tachycardia (VT). If this occurs, treatment is usually instituted, since VT may lead to ventricular fibrillation.

Special Problems

Prematurely born babies have as high as a 90% incidence of arrhythmias.⁴ This is probably due to the immature autonomic system. Arrhythmias include marked bradycardia, premature beats and varying heart block. These arrhythmias seldom persist.

Rheumatic fever may show some of the following EKG changes in the acute phase: 1) conduction disturbance, including varying degrees of heart block; 2) prolongation of the Q-T intervals; and 3) S-T and T segment abnormalities. It should be stressed that 1° AVB as manifest by P-R prolongation is *not* specific for acute rheumatic fever; and 2) serial EKGs should be obtained to show a changing pattern. Rheumatic heart disease (non-acute) may show hypertrophy of atria or ventricles as produced by chronically altered hemodynamics.

Digitalis has profound effect on

the EKG. Acting as a vagal mediator, it causes slowing, especially at the A-V node, but also produces myocardial irritability. Digitalis effect is manifest by slowing, P-R prolongation, and S-T changes. Effect differs from toxicity; this latter often results in extreme bradycardia, advanced heart block, junctional rhythm or premature contractions. If there is a suggestion of digitalis toxicity, the drug must be withheld and further measures instituted as necessary.

Electrolyte abnormalities in children are usually suspected clinically. The EKG may offer confirmation or guide therapy. The EKG findings produced by electrolyte abnormalities are similar to those seen in adult electrocardiograms.

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Laetrilomania

In a recent *New England Journal of Medicine* editorial, Ingelfinger coined the word "Laetrilomania" and wisely pointed out the adverse effects of "establishment indictment" of unproven nostrums. "Forbidden fruits are mighty tasty, and especially to those who hope that a bite will be life saving."¹ Legislative action in Indiana and other states has created further emotional confusion for the cancer patient. It is absolutely imperative that physicians be informed about these issues and provide their patients with current, pertinent information on Laetrile.

It is important to publicly and individually reaffirm our unwavering allegiance to the cancer patient. In our zeal to protect patients from unproven remedies we have the *appearance* of looking after physician interests first and patient interests last. Public, patient and professional support for reason and scientific logic will follow once there is an understanding that the physician will always stand by his patient regardless of the treatment choice selected.

There are two clearcut sides to the Laetrile issue. One side is built on personal testimony and carries great emotional appeal. The other side is based on reason and scientific fact and, therefore, has very little emotional appeal.

Laetrile proponents claim that it is vitamin B17.² No evidence has been presented that it actually is a

vitamin. There is overwhelming scientific evidence that it bears no resemblance to a vitamin.³ These same proponents also claim that all cancer is a deficiency disease. True deficiency diseases like pellegra, scurvy, rickets and pernicious anemia can be virtually 100% cured (defined as normal life survival) when the missing nutritional factor is given. This is true even when patients with these diseases are desperately ill. If cancer is a nutritional disease, why doesn't Laetrile cure cancer 100% of the time, too?

Laetrile proponents claim that it is being used successfully in 27 other countries; yet not one single scientifically acceptable paper has been published in the world medical literature which shows any benefit in the treatment of human cancer. Dr. Contreras of Tijuana, Mexico, is a pathologist who has treated thousands of cancer patient since he opened his clinic in 1970, yet he has not published a single paper stating Laetrile is of benefit in the treatment of human cancer. Proponents claim that Laetrile is legal in these same 27 countries. It is not that it is legal but that it is not illegal. Most of these countries lack health regulatory agencies such as those in the United States and Canada.

Proponents of Laetrile continue to talk of positive results at Sloan-Kettering and a coverup of such information. This is not true. Officials there continue to point out that there were not any positive results when the original Sugiura experiment was repeated in double-blind fashion.^{4,5} These results are soon to be published in the *Journal of Surgical Oncology*.⁵

These same proponents claim that, at the very least, it relieves pain; yet not one single scientific paper has been presented that shows the relief produced was any greater than what would have been expected if a placebo had been given.

Laetrile proponents claim that it is useful in the treatment of sickle cell anemia.⁶ Scientifically, this claim is absurd. If the claim for

treatment of sickle cell anemia is absurd, is it not highly probable that the claim of effective treatment of cancer is equally absurd?

The idea that a person has a right to choose freely any course of conduct he or she may wish to pursue without interference from government cannot be accepted without qualification. It is true only as long as the conduct does not infringe on the rights of others. The use of Laetrile clearly infringes on the rights of others.

There is a common feeling among health professionals that the government is too big and that the Food and Drug Administration requirements are inhibiting drug research in this country. This, however, does not legitimize products such as Laetrile, whose proponents, likewise, are against big government. *Two wrongs don't make a right!*

There is a sound and effective way by which claims for new treatments of diseases are examined, and this "due process" of science has served mankind well throughout history. This process consists of presenting evidence in an orderly manner, according to accepted forms, to one's medical and scientific colleagues. Tens of thousands of medical meetings are held all over the world every year and more than 3,400 medical journals are published regularly—all for one purpose—to provide a forum for those with something worth reporting to the scientific world. Proponents of Laetrile are asking that we bypass this "due process" of science.

Ingelfinger points out the importance of accurate record keeping. We should not compromise our scientific integrity by making exceptions to established methods of testing. Furthermore, we need to recognize that no amount of testing will ever satisfy the Laetrile proponents. Accurate record keeping can provide studies which will, however, satisfy most physicians.

Most physician response to Laetrile is "We all know the stuff isn't any good, but why not give it to

Aunt Millie if she is dying and all reasonable methods of treatment have failed?" This position is very damaging and is wrong. For example, suppose Aunt Millie takes Laetrile and then goes on to die a short time later. By the time the story gets around, it was a miraculous cure or at the very least, Aunt Millie died in complete relief from pain. The obvious danger is that people who can be cured will come to cooos the "magic bullet" instead of proven effective methods.

There are logical reasons people legitimately think they have been helped by any unproven remedy:

1. Spontaneous regression—rare (1 in 50,000).

2. Mistaken diagnosis—infrequent.

3. Never had cancer in the first place—not infrequent. (Laetrile clinics seldom insist on biopsy proof of cancer.)

4. Treatment with standard modalities of therapy followed by Laetrile, with success of treatment attributed to the latter—frequent.

5. Lack of knowledge that Laetrile clinics use *standard proven* methods of treatment (i.e., surgery,

chemotherapy, radiotherapy, hormonal therapy and immunotherapy) in addition to Laetrile—frequent.

6. Failure to recognize the variability of cancer, the confusing terminology of cancer and the natural history of the disease—frequent.

In this day of consumerism and increased honesty, physicians too often tell patients with fatal problems that there is nothing else reasonable to do. American people traditionally won't accept failure and will grasp for any straw. Most want to continue fighting. Our counseling needs to be: "There is *always* something to be done." We can at the very least guarantee symptomatic control. Additionally, there are always experimental programs to offer to any patient who wants to fight to the end. Never cut the thread of hope! Involve qualified paramedical and lay support to help the patient and the family.

It is also important to be aware that this legislation will be followed by a proliferation of other unproven remedies—i.e., diet fads, megavitamins, B₁₅, coffee enemas, "grape cure," "asparagus cure," etc. The

American Cancer Society has an extensive supply of literature about Laetrile and other unproven remedies. I urge you to contact them and obtain these materials. Urge your patients to trust science to treat cancer, not emotion.

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* * *

**EVERY PHYSICIAN'S OFFICE—
A CANCER DETECTION CENTER**

* * *

WILLIAM M. DUGAN, JR., M.D.
President, Indiana Division
American Cancer Society

From THE JOURNAL 50 Years Ago

When I meet a broken leg I examine first the top of the foot and note the character of the pulsation of the dorsalis pedis. If it's good and strong, I know I have a fighting chance to save the leg. This one was good and strong. "John," I said, "I think I can save your leg." The gloom was dissipated, with a whoop he exclaimed, "Bully for you, Doc." I called the hospital to have everything ready for a bad compound fracture of the leg. We were soon there and in the emergency room, John cleaned, and one-fourth morphia in his arm. Under the anesthetic we proceeded to reduce the fracture. We didn't, for with the assistance of two interns, a husky orderly and anethetist pushing to the limit, we could not budge it. The muscle of the calf was in a tetanic condition. Then I remembered Dr. Webster. Sending for a tenotome I divided the tendon and found I was master of the situation.

Two surprises met me. First, the small amount of retraction of the severed tendon; second, the ease with which I could handle the bones, no difficulty in restoring them to their proper places and retaining them. I applied a circular cast and he came out with a leg he says is as good as the other. No pain or limp, does his hard labor each day, without trouble. He came in not long ago to show how fine it was. A thickening at the point of fracture is the only blemish. . . .

I always watch my cases closely. See them, if possible, daily. Don't trust them to internes, for so many internes don't like to bother with them. I can only recall one who has always been ready and anxious to learn more. . . . George F. Beasley, M.D., Lafayette, "Division of the Tendo-Achilles in Fractures of Lower Limbs," *JISMA*, September 1927.

When Griseofulvin is indicated...



TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



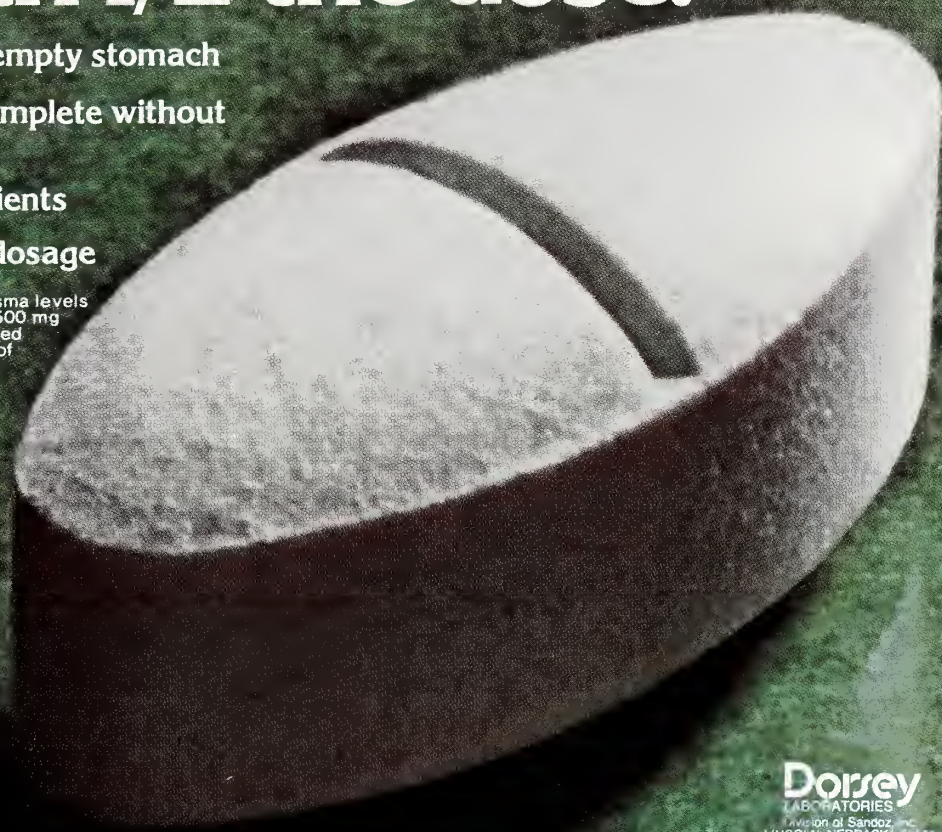
TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG[®] (griseofulvin ultramicrosize) Tablets 125 mg offers effective therapy with 1/2 the dose.[†]

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

[†]250 mg of Gris-PEG[®] provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.



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(griseofulvin
ultramicrosize) Tablets
125 mg

The ½ dose griseofulvin.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG Tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsize griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections:

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis, ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleinii
Microsporum audouinii

Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *NOT* effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5 to 2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatoma in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral ad-

ministration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress. Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSEAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potas-

sium hydroxide or by a culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months, toenails, at least 6 months. General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsize) USP (see ACTION Human Pharmacology).

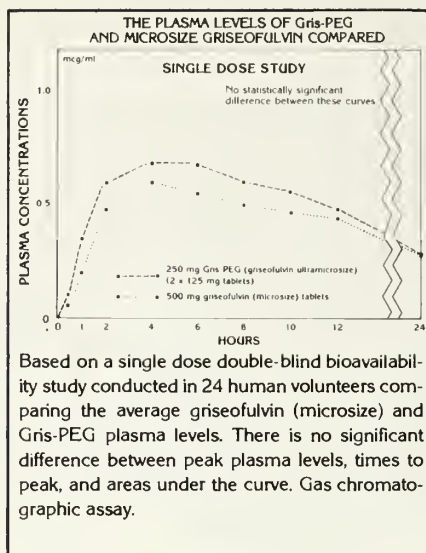
Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis the following dosage schedule for children is suggested. Children weighing over 25 kilograms (approximately 50 pounds): 125 mg to 250 mg daily, children weighing 15-25 kilograms (approximately 30 to 50 pounds): 62.5 mg to 125 mg daily, children 2 years of age and younger, dosage has not been established.

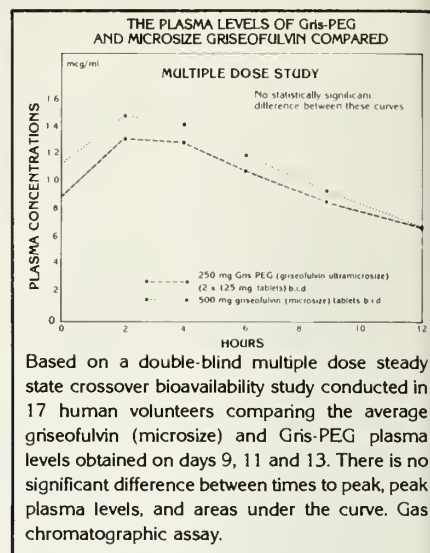
Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin microsize tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin, biologically equivalent to 250 mg of microsize griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsize griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

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Cyclists and Helmets

IN a recent report entitled "Head Protection for the Cyclist, A Medical Inquiry," the American Medical Association strongly recommended that no one should operate or ride as a passenger on a motorcycle, moped, or even bicycle without wearing a helmet.

The report, issued by AMA's Department of Health Education, is the result of a recent special conference on head protection sponsored by the AMA, as well as a survey of scientific literature on the subject. The conference consisted of 20 experts, including physicians, medically oriented researchers and representatives of the motorcyclists, as well as manufacturers.

Although the report purposely avoids the issue of compulsory helmet legislation, which is being challenged by motorcyclists throughout the country, it effectively refutes many of the arguments used in influencing legislators to repeal state helmet use laws.

In response to the argument often used that helmets *cause* cervical spine and clavicle injuries, the report states categorically that "helmets do not of themselves contribute to or worsen the injury." The report states further that if forces are strong enough to cause such an injury to the spine with the helmet, those forces would almost invariably cause a fatal head injury to the unhelmeted cyclist if

his head struck the pavement or other unyielding object in a crash.

The report also refutes the claim that the helmet causes a serious reduction in peripheral vision, by pointing out that all helmets approved by the U.S. Department of Transportation already *exceed* the requirements of any state driver's licensing agency, and, further, that the great majority of cycle crashes occur within the 40 degrees of field vision directly in front of the cyclist.

As for helmets impairing hearing, the report points out that any reduction of critical traffic sounds by the helmet is proportionate to the reduction it makes of the sound of the cycle. Thus, if the helmet does not completely block out the sound of the cycle (which no one claims), neither does it block out the necessary traffic warning sounds.

What about the claim that actual hearing *damage* can be attributed to helmets? The report states that since the helmet reduces both the sound of the cycle and the sound of the normal traffic stream, it can hardly be blamed for hearing damage. The report notes, however, that *continuous* exposure to even ordinary motorcycle and traffic sounds can cause hearing loss. Accordingly, the helmet can actually be helpful in reducing the chance of hearing damage.

In addition to these major subjects, the report discusses the effects of helmet weight, chin straps,

chin cups, head rotation within the helmet, speed, alcohol involvement, helmet accessories, tinted shields and visors and thermal effects. Also discussed was the proper removal of a helmet to avoid any further injury to a cyclist who has been in a crash.

Finally, the report not only strongly condemns cycle use without a helmet, but recommends specifically the use of full-facial coverage helmets because of the extra protection they afford. It recommends also that, because of the serious public health implications, the medical and health community should actively involve itself in promoting the use of safety helmets by all who drive or ride two-wheel cycles, particularly motorcycles.

Rationing of Medical Care

Inherent in the last few years' discussion of rising medical costs is the nagging, but largely ignored, question of how much money should be devoted to medical care. Many think we are spending too much—that the percentage of gross national product which has been devoted to medical care, since it is rising, is out of proportion.

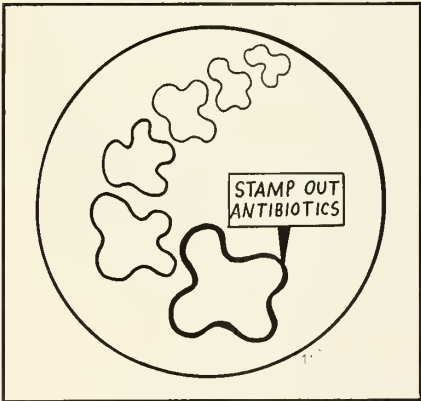
Others think that not enough is spent—that there are gaps in medical service that should be closed. Whether those citizens who don't receive what is considered minimal

attention are on the short end due to their own indifference or to lack of money or to shortage of physicians is not pertinent to the issue of how much should be spent in an ideal situation.

It is, however fairly evident that, if everyone received optimal medical service, the bill would be higher—a lot higher. This conclusion is valid even though hospital prices and doctors' fees were lowered by a considerable degree.

As a matter of fact, there is not enough money in the world to furnish top-notch, A-1 complete medical service to all Americans if such care were to be made available without limitation. Medicine has already progressed to the stage which makes it economically impossible to apply it to everyone. The thought of providing kidney transplants to everyone who would benefit, of rendering proper hospital-based care to everyone with a peptic ulcer, of providing 100% dental care to all, or of doing a first class history and physical examination for all citizens once a year or oftener—just this much is staggering to the imagination. And add to this the enormity of the task of providing all the mental health and psychiatric care which is so urgently needed.

Dr. Richard Palmer, in his talk as outgoing president of the AMA, spoke eloquently of the problem. He viewed it from what might be called the other end, the end that is occupied by the federal government. The richness of medical science and all its assets and refinements is enough to suggest that, in the future, there must be some method of rationing care.



Dr. Palmer spoke of rationing in order to introduce his thoughts on efforts of the government to control hospital expenditures and to lower physicians' fees and, in general, to decrease the cost of care. Those who propose to do this always emphasize that all this must be done without lowering quality, an undertaking which is noble but practically impossible.

Dr. Palmer's talk was devoted not so much to the prevention of rationing, although he views any thought of rationing with distaste, but mainly to the methods proposed by the government to control cost—a method which Dr. Palmer states will result in rationing. And, whether rationing is desirable or not, and whether it could be satisfactorily realized without harm to the nation or not, the methods now on the front burner in Congress would make a shambles of the best medical service in the world. Agreed.

Limiting hospital expenditures by 9% is akin to tying down the safety valve on a steam engine. It can be done but the results are disastrous. With standard inflation rampant year after year and with the customary advances in medicine (all expensive) the result will be deterioration of service and care. Some little fat may be trimmed in the process but at a horrible price.

If the government wants to halt the inflation of costs of medical care there are only a few things that need to be done. Such as: prohibit all medical research, prohibit all advances in diagnosis and treatment, balance the federal budget and eliminate inflation of all other goods and services. That would do it, but that is not the way we are going.

So, to quote Dr. Palmer: "No individual—and ours is a nation of individuals—wants his care to fall victim to cost-effective common denominators. No individual wants his own care to be rationed."

Sometime in the future medical care should come under some equitable system of proportionment but the present government methods are not the best way.

Editorial Notes . . .

A new special section, the **Resident Physicians Section**, was inaugurated at the recent annual meeting of the AMA. The Section has about 11,000 members and has elected a full staff of officers, delegates and alternate delegates, representative on the AMA Council on Scientific Affairs, and representative on the AMA Council on Medical Service. The AMA Trustees have appointed two other of the Section members to AMA Councils.

Numerous friendly and some not-so-friendly criticisms of the FDA have been based on the fact that the U.S. is often the last civilized country in the world which is able to benefit from a new drug. The problem has been investigated by inviting testimony, usually by experts, all with some degree of bias. The result has been a standoff. No one has yet convinced the FDA that its process is slow even though most drugs released for use in the U.S. have, by history, been in general clinical use overseas for several years. Now, the House Science and Technology Committee has asked the Government Accounting Office for a study of the U.S. drug lag. By next spring GAO hopes to have the answer.

Treatment of depressed women at Cleveland Metropolitan General Hospital has been significantly improved since psychiatric data have been computerized. The computer record starts with a diagnosis or several diagnoses together with elaboration of specific patient problems. Therapy, which is monitored by some 45 individuals, is later added to the computer record. The final data are compiled after the patient is dismissed. Results of treatment are matched against various therapies. Choice of therapy for new patients is based on the most effective method for any particular variation of depression which is observed. ◀

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National Health Insurance

JAMES HOWELL SULLIVAN, M.D.
Columbus, Ga.

I would like to present a few facts, a few questions, and a few answers regarding the possibility of National Health Insurance for America. The facts are correct. We must disseminate this information to educate our citizens and forewarn them of this bureaucratic nightmare.

The tragic flaw in any federal, social, or health program is the bureaucracy formed which controls it. This usually comprises 20-50% of the total expenditure of these funds.

Social welfare spending hit an all-time high in 1976. The Department of HEW says that during 1976 social welfare programs cost the nation's taxpayers \$331 billion (\$45 billion more than it cost the same taxpayers in fiscal 1975). Social welfare programs in 1976 cost each American citizen, man, woman and child, \$1,760.19. In 1960 only 26% of the federal budget was spent on social welfare programs, but in 1976, 56% of the federal budget was spent on social welfare programs.

A very interesting statistic is that 6.6% of the income of the nation's families went toward total health care cost in the United States, which totaled 140 billion dollars in 1976. This includes insurance, medicine, medical bills, hospital bills, glasses, dentures, etc. The taxes paid to the United States, state and local governments took 34% of the income of families of this United States.

Why do we have rising health care cost? No longer can Washington accuse us doctors of being some 50,000 short in numbers. Washington cannot refute the peerless excellence of American medicine as compared to worldwide medicine. Washington cannot deny what the polls show, and that is that most Americans are satisfied with the

quality and with the availability of their care. Rising costs are being exploited as an excuse for an all-out move against the private practice of medicine and health care. We doctors are concerned about the cost issue but, contrary to the thinking of most politicians, we are not the culprit. The climb in cost is largely due to impersonal factors that far exceed the personal ability of any health care provider to control them. They are: 1. growth and expansion of clinical competence and technology; 2. growth of health insurance and its incentives to better care; 3. the relentless surge in professional liability premiums; 4. greater longevity and, thus, a greater incidence of chronic illness (in other words, you cure one disease, the patient lives longer and is certain to get a second disease process); 5. steady inflation, and 6. most important, the network of administration and procedural expenses engendered by federal involvement in health care.

Did you know that hospitals employ five times as many people as the automobile industry? (two million people work in hospitals). Did you know what the impact of an increase in the minimum wage on hospital cost is? Raising the minimum wage in areas such as housekeeping, laundry and kitchen also causes a ripple "effect" which raises salaries of other personnel to maintain a rational wage structure. A 30¢ per hour increase in 1974 of the minimum wage initially had an impact of \$29 million on hospital wages, but the ripple effect had an impact of \$450 million. Did you know that each hospital patient in the United States in 1976 paid an average of \$6.00 per day to cover malpractice insurance costs for the hospital? Did you know that one in three hospital employees have spe-

cial training as opposed to one in seven people in industry?

When socialized medicine and national health insurance fails, as has happened in England and other countries, the blame will not fall on the government, it will fall on the physicians, hospitals, nursing homes, and pharmacists. National health insurance will bankrupt this nation just as surely as it has England. The private practice of medicine, like the private enterprise American system, is based on the principle that a person is entitled to what he earns and pays for.

The record of HMO or Health Maintenance Organizations in the United States is simply awful. Co-op health groups traditionally have administrative costs amounting to from 50-97% of the total money available. National Health Insurance and HMO group medicine invites assembly line medicine. Liberal congressmen and politicians have ignored the overall rise in cost of living and basic cost of inflation which, in essence, is uncontrolled deficit spending by government itself.

The annual budget of HEW (which is a bureau determined to cut costs and transform American medical health care) is greater than the total cost of all health care in this nation today. If honest cost savings were the real issue, the greatest boon to the American citizen today would be the abolition not of the practice of private medicine, but, rather, of the Department of HEW.

Let's think of catastrophic illness and insurance. Catastrophic illness insurance is thought necessary by many but when the facts are known it is a typical bureaucratic sham. A \$10,000 bill for the patient in the hospital is extremely rare. Three out of 1,000 patients have expenses

over \$1,000 and 80% of these are either Medicare or psychiatric patients. A family of four in the 25-35 age bracket would pay \$52 a year to a private insurance company for a \$10,000 deductible catastrophic insurance policy. Studies by private insurance companies as well as by a government-appointed study committee reveal that catastrophic national health insurance the first year would cost \$370 for the same family of four in this 25-35 age group. Where is the extra \$318 per year to go? To bureaucratic boondoggling.

If smarter brains could prevail, the cost of a citizen's health insurance could be a direct tax credit against the federal income tax so that a taxpayer could deduct the entire cost from his tax bill. This would certainly be superior to the halfhearted deduction that now exists.

Any open-ended program such as national health insurance will encourage unnecessary utilization of benefits. If our medical system is indeed approaching a crisis due to rising costs, it is not because of the lack of government planning or intervention, but, rather, because of the sheer weight of all government programs, regulations and paperwork they entail. A government that cannot even run a medical program for the poor and aged, or deliver the mail on time at a reasonable cost, can hardly call itself qualified to administer a national health insurance program. Of all the proposals for national health insurance, the overwhelming idea is to try to provide cost containment, but never once is mentioned the quality of medical care.

Our medical records can always be surveyed by the prying eyes of bureaucrats. The national health insurance PSRO standards will expose even your most private records

to anyone in government. On a computer with your one big number will be your health record, any legal problems, income tax returns, bank accounts, parking tickets, court decisions, credit cards, financial statements, misdemeanors, licenses and down-the-line.

The arrival of Mr. Carter at the White House with his ideas of national health insurance makes it more than ever necessary for Americans to see what can be learned from Britain's example for national health insurance. In seven years the number of administrative employees of the British health service increased almost twice, from 780 thousand to 1.3 million non-medical administrative employees. British doctors say bluntly that their British National Health Service is on the brink of collapse. The British patient can see nothing very wrong, even though he has to wait a long time at a clinic and up to a year or more for non-urgent hernia operations. The reason for this is that the British people have never known anything else. They are accustomed to second class standards of medical service because it took 30 years for the superb medical care of Britain to demise. The truck with defective brakes and steering is no less headed for disaster in the early stages of its run downhill than when it crashes through the brick wall at the bottom. But the truck was actually doomed from the start unless someone had managed to deflect it.

Even though Carter advocates national health insurance, Senator Kennedy is intent upon the passage of a bill that bears his name. Senator Kennedy has said that if anything else is passed for national health insurance other than his own health security plan, this country will wither and die. Senator Ken-

nedy will not let a Georgia peanut broker take over his medical field.

The financing for national health insurance will amount to a political and financial nightmare. It is anticipated by the same actuary firm which studied catastrophic insurance programs that over \$130 billion in start-up funds would be needed for the first year of a comprehensive national health insurance.

HEW recently released the list of physicians who in 1975 received large sums of money. Of the first 112 doctors checked only 32 were correct as listed. One physician had retired 12 years previously and was listed as receiving \$233,000. Another physician who had died in 1974, one year before the time period, was listed as receiving \$250,000. The list of physicians released by HEW has got to be one of the sloppiest performances in the history of American bureaucracy. If the AMA were to put out data this inaccurate the press would have us for breakfast and properly so. For this reason HEW ought to be held similarly accountable.

What can we do? 1. Education. We can inform the public by spreading the flaws of the cost and the bureaucratic nightmare of national health proposals. 2. We can encourage congress to repeal the PSRO and HSA laws and other social legislation programs and try to keep a right to privacy in our record keeping system. 3. We can court the press. It is so easy to be against something, but it is very difficult to stand up for something such as private enterprise, the private practice of medicine, the right to work, the right for freedom, and the right to be an American citizen. —Reprinted from the *Muscogee (Ga.) Medical Society Bulletin* with the permission of the author.

THE 1977 ROSTER OF MEMBERS—Additional copies of this year's Roster are available. Price to ISMA members is \$5.00; to all others, \$10.00. Please send check with order.

Places to Go

Things to See

In Indianapolis

SALLY BEELER
Indianapolis



No doubt some of you have completed arrangements and made reservations to attend the Convention of the ISMA to be held this year Oct. 23 through 26 at the new Indianapolis Hyatt Regency Hotel. It is my hope that those of you who are "on the fence" in your decision-making will definitely decide to be a part of this meeting and to enjoy some of the available activities in Indianapolis as well as the meetings themselves.

Indianapolis is proud of the many improvements visible in the downtown area over the past few years, among the latest of which is the construction of the beautiful Hyatt Regency within the Merchants Bank Plaza, the site of this year's convention. Among the new restaurants introduced in the area is the La Scala on South Meridian Street; previously a candy and tobacco warehouse, it is now an elegant and attractive dining room. The King Cole Restaurant continues to be one of the most highly rated establishments in the country; the La Tour atop the Indiana National Bank building offers some of the finest cuisine as well as a panoramic view of the city. Other restaurants high over the city are located in the Hilton Hotel and the Hyatt Regency.

For a novel foray, you might want to drop in at the newly renovated City Market, pick up a loaf

of bread and some cheese, and then over to 205 North College Avenue to visit Easley's Winery—one of the few wineries in the state—to sample the products of their vineyards, which are located in the Big Bend area of the Ohio River near Leavenworth.

Those of you with an artistic bent may want to visit the Indianapolis Museum of Art, 1200 W. 38th St. (a major exhibition of Sheffield plated silver is scheduled for that time), the Children's Museum (now just one year old), 3000 N. Meridian St., or the Indiana Medical History Museum on the grounds of Central State Hospital, 3000 W. Washington St.

In the near downtown area great strides are being made in the restoration of Lockerbie Square. Many young couples are purchasing dilapidated old homes in this historic part of the city and refurbishing them for their own family use.

If a trip to the outlying districts appeals to you, you will find the quaintness of Zionsville Village most interesting with its many shops and colonial decor. An innovative shopping area, the Bazaar, is located at North Keystone and 86th Street and consists of more than 30 varied shops in an open setting, as well as five different restaurants. The development, known as Keystone at the Crossing, also boasts

fine stores such as Gattle's (linens), Mr. Blackwell's (clothing), N. Theobald (glassware and gifts), and the Pan Handler (kitchenware). Good time to Christmas shop!

The committee for women's activities has scheduled golf and tennis for Monday afternoon, and has also planned a tea at the Governor's Residence, with Mrs. Otis Bowen as hostess, on Monday afternoon. Buses for transportation to and from the tea are being provided by Eli Lilly and Company. Tuesday morning there will be a meeting of the Medical Auxiliary officers and Board, to which everyone is invited, to be followed by a Lunch-Matinee at the Hyatt Regency Hotel. This being the 50th anniversary of the Auxiliary, past presidents will be honored at that time. Details of women's activities will be mailed to doctors' wives so that reservations may be made.

If this article appears to be a Chamber of Commerce sales pitch, it actually reflects my pride in Indianapolis and a sample of what it has to offer in the way of pastime and entertainment.

John and I do hope that the need for a break in your routine will dictate a trip to our convention in October, and we welcome each of you. Let us know if we can offer any assistance!

The Royal College of Surgeons of England

MALCOLM B. HERRING, M.D.
Indianapolis

IN the January and March issues of the *Annals of the Royal College of Surgeons of England*, a number of excellent clinical articles were published. C.W.O. Windsor, F.R.C.S., discusses certain aspects of the management of acute intestinal ischemia. The etiology of occlusions of the superior mesenteric artery is as often embolic as atheromatous. This contrasts with the uniformly atheromatous occlusions of the inferior mesenteric artery. A hypercoagulable state predisposes to venous occlusions of the mesenteric system. This accounts for one third of the cases of intestinal gangrene. Non-occlusive ischemia follows low cardiac output syndromes. One is obligated to operate on suspicious cases without

utilizing time-consuming confirmatory tests. Both pre and postoperative, nasogastric aspiration and broad spectrum antibiotic therapy are recommended. Revascularization and debridement of dead bowel comprise the operation. A second-look operation is performed after 24 hours. Following these technics, 30% of Windsor's patients survived. These 30% had massive resections at the first operation. Attention to postoperative fluid and nutrition are important. Massive postoperative fluid, chloride and potassium losses from the nasogastric tube warn the surgeon that further dead bowel may be present.

* * *

E. A. Benson, F.R.C.S., suggests

the wrapping of abdominal aortic aneurysms with Marlex Mesh. The lumbar arteries are divided. The abdominal aortic aneurysm is completely mobilized off of the vertebral column. The Marlex Mesh is passed around the aorta 2½ times, forming two posterior layers and three anterior layers. The end of the wrap is sutured to the underlying wrap. This technic was applied in two poor risk patients with good results. The follow-up was 2½ and 3 years.

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From the *Annals of the Royal College of Surgeons*, January and March issues, 1977.

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BOOK REVIEWS

SOUTHWESTERN MEDICAL DICTIONARY (SPANISH-ENGLISH AND ENGLISH-SPANISH)

Margarita Artschwager Kay, University of Arizona Press, Tucson; paperback, 217 pages, \$3.75 (available clothbound at \$9.50).

The foreword describes this dictionary as bilingual, technical, regional, and colloquial. It contains "some 1,200 separate entries in English and more than 1,300 in Spanish." In the Spanish-English section there is included with each entry a sentence in Spanish which incorporates the term, followed by a translation in English of the entire sentence. This is essentially a handbook designed for health care personnel who are normally English speakers dealing with Spanish speakers of southwestern United States. As such, it is a well thought out accomplishment and should be invaluable to such workers, from physician to nurse aide.

In addition, there are appendices containing glossaries of foods and their preparation, plus a long list of terms used to express kinship. The appendices alone would make this book of lasting value to any student of Spanish who intends to use that language in work or travel. It is entitled a medical dictionary, but the material has been derived from lay people (many of them with little education) and, therefore, can be understood by anyone. Incidentally, extremely familiar or intimate terms are labeled as "colloquial", included because they may be used by a patient, although it may not be appropriate for the health worker to address the patient with such terminology. This is cited to emphasize the books' practicality.

A. W. CAVINS, M.D.
Terre Haute

TRANSACTIONS OF THE AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS, VOLUME LXVII

Williams and Wilkins, Baltimore, 1975.

The original reasons for forming the American Association of Genito-Urinary Surgeons may someday be obsolete but the organization continues to bring together the name urologists from this country and Canada, with some foreign "corresponding members." These men are all professors and tend to be the more mature leaders in the specialty. Once each year they meet and the papers presented at their meeting (at the Key Biscayne Hotel, Florida, in 1975) comprise this journal.

The magazine is a somewhat unique production. The first pages include obituaries of old-time urologic luminaries William Braasch and Howard Suby and the late great Wyland F. Leadbetter of Harvard. This latter man was tops in urology for 30 years. So, firstly, the "Transactions" serve as a vehicle for memorializing deceased members. Also, the so-called "Ballinger Medal" was presented to the living Hartwell Harrison.

There are, by my count, 28 papers in all and each set of one to three is followed by "Discussion" from the other members. The papers include topics such as home urine cultures, self catheterization (by the inventor of "clean catheterization technic," Jack Lapides of the University of Michigan), "evidence for a new mammalian organ" (near the juxta glomerular apparatus in the kidney), radiotherapy for carcinoma of the prostate, thymectomy for renal transplant survival, radiculitis mimicing renal colic and, finally, a grand article by Mr. Turner-Warwick of England regarding the manifold uses of the omentum to increase vascularization and as a stint for the regrowth of the urothelium. There tends to be some elemental status to the papers selected by these professors for reading to their own peers. The most engaging information for the reader are the trenchant commentaries by the listeners. As when William Boyce of Winston-Salem, N.C. (Bowman Gray Medical School), says: "I rise to support completely both of these papers . . ." He was commenting on the use of omentum as presented by Chester Winter of Columbus, Ohio, and Turner-Warwick.

I think there is an exceptional vista of knowledge in this book of papers by teachers for teachers which is rich in the nuances, and it is worthwhile reading, albeit only for urologists or paraurologic personnel.

RODNEY A. MANNION, M.D.
LaPorte

NOTES OF A FEMINIST THERAPIST

Elizabeth Friar Williams, Dell Publishing Co., Inc., New York, a Laurel edition, reprinted by arrangement with Praeger Publishers, Inc., 1977; 214 pages plus index; \$1.50.

This small book really is a series of "notes" rather than a treatise, although there is a planned arrangement of the

Continued

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notes. It is a compilation difficult to review, because of a certain inconsistency (which, of course, could be in the male chauvinist pig's mind). In more than one instance the author builds up what seems a very thought out analysis, only to suddenly extinguish the intellectual illumination by a shower of feminist propaganda, too often couched in unnecessary vulgarisms.

The effect of this ploy on the reader is first astonishment, then disdain, then a feeling of having been gulled. The author accomplishes this by a sudden change from apparently scientific psychological analysis to gutter language and point-of-view. If she insists on four-letter words to make this approach she has chosen a very poor one for her favorite, because it happens to be a term not only meaning sexual intercourse, but it also for many generations has been in low use as an epithet and in general cursing; in other words, gutter, barracks and barroom language, indicating a poverty of diction in the user. Incidentally, she herself uses this same word (which begins with an f) in both the connotations mentioned above.

This is dwelt upon to show the great difficulty one has in evaluating the work and opinions of a therapist who seems

to have so little regard for the true meaning of sexual love (human, that is) by placing it on a pretty low basis. It suggests, perhaps, that she is uncertain of her own "liberation" and has to prove she is "one of the gang."

On the other hand, this may indicate that she is writing not for the intelligentsia but for the less discriminating. She is able, for instance, to blame all the psychological ills of women upon the dominant position of men, even to the extent that her desire to have a child was "learned" and not instinctive. She blames a good many things on the organization of society that she should argue about with Mother Nature—she has the cart before the horse.

This book should, therefore, be judged by its title taken literally. It will be highly informative to any practicing physician who reads it in the matter of discovering what some types of "therapists" are imparting to their clients, since he may have a patient who is such a client. From this book he will obtain valuable insight into a field which may well have escaped his ken.

A. W. CAVINS, M.D.
Terre Haute



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Continuing Medical Education

The following Indiana physicians are recent recipients of the AMA's Physicians Recognition Award. This award is official documentation of CME hours earned and is acceptable proof, in most states requiring CME in re-registration, that the mandatory hours of CME have been accomplished.

Alan J. Adler, Kokomo
Domingo L. Ang, Richmond
William F. Bastnagel,
Indianapolis
Thomas H. Black, Greencastle
Donald S. Chamberlain,
South Bend
Dean L. Cook, South Bend
William V. Croft,
New Albany
Walter F. Florczak, Hammond
James M. Franco, Evansville
John A. Forchetti, Chesterton
Illuminada C. Hernandez,
East Chicago
William L. Hildebrand,
Indianapolis
John C. Johnson, Indianapolis
Karl C. Kohlstaedt,
Indianapolis
John T. Lucas, Fort Wayne
Frances J. Masser,
Jeffersonville
John Mealey, Indianapolis
Leon G. Michl, Canaan

Robert L. Morris, Seymour
Magaral S. Murali,
Indianapolis
John B. Nicosia,
East Chicago
Leonora G. Noel, Warsaw
Jose G. Panszi, Muncie
John B. Parker, Indianapolis
Cesar E. Perez, Carmel
Seth S. Philbrook, LaPorte
Ambrose M. Price, Anderson
Robert J. Robinson,
Greenwood
Harry G. Rotman, Jasonville
Jaime A. Salomon,
Indianapolis
Carlson R. Speck, Muncie
Dennis E. Stone, Columbus
Wallace S. Tirman,
Mishawaka
Robert W. Turgi, Gary
William C. Van Ness,
Summitville
William L. Wagner, Danville
Charles J. Yast, Merrillville

Miles to Develop, Market Hormone

Miles Laboratories has obtained a license to develop and market Thymic Humoral Factor (THF). An agreement between Miles and Yeda Research and Development Co., Ltd. at the Weizmann Institute of Science in Israel will allow Miles to further develop the hormone, obtain FDA approval for its sale and then market it worldwide. The hormone appears to be applicable to conditions characterized by deficiency in immune mechanisms.

Dr. Headlee, Parasitologist, Retires

Dr. William H. Headlee, a native of Shelby County, and a teacher at I.U. School of Medicine since 1943, retired this summer with the title of professor emeritus of parasitology. His first task at I.U. was the training of doctors in tropical medicine, a crash program because of World War II. Later he organized and directed the Parasitology Diagnostic Laboratory and progressed from assistant to full professor of parasitic diseases.

Community Hospital Honors Physicians

Dr. Ray C. Smith, Jr., Indianapolis, was named the "medical education physician of the year" by Community Hospital at the institution's third annual Physician Recognition Banquet.

A special award was presented to Dr. George F. Parker in appreciation for his many years of service to the Medical Education Department, which he was instrumental in helping to establish.

Dr. William E. Kelley, director of family practice and acting director of medical education, was in charge of the program.

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Security Systems Subject of Booklet

Dictograph Security Systems has a booklet entitled "What Every Doctor Should Know Before Selecting a Burglar, Hold-Up and Fire Alarm System." It contains a list of things to consider in comparing protective systems and an offer for a no-obligation survey of professional premises and recommendations for the proper installations. Write Dictograph Security Systems, Department D, P.O. Box 96, Florham Park, N.J. 07932.

Nursery Benefits from Show

The Welborn Baptist Hospital, Evansville, recently benefited from a fund-raising performance in the amount of over \$52,000 which will be utilized for special equipment in the nursery. Alan B. Graf of the Keller-Crescent Company of Evansville, president of the hospital's board of directors, headed the affair and had the assistance of Bob Hope and Anita Bryant. A slide and audio presentation with narration by Hope about the high risk nursery was shown to the audience and is now available to civic organizations and hospital groups elsewhere upon request.

Two Hoosiers Serving AMA

Dr. Lowell Steen, Hammond, was elected to the Executive Committee of the American Medical Association at the group's annual meeting in San Francisco.

At the same meeting Dr. Patrick J. V. Corcoran, Evansville, was renamed to the Council on Medical Education.

Drs. Templin and Smith Honored

Drs. David B. Templin and Robert D. Smith were honored recently by residents of the Lowell area for their many years of service to the community. Dr. Templin's 25 years of service were memorialized by the creation of an annual scholarship in his name for a Lowell High School student.

Dr. Smith recently left the Lowell Clinic after 17 years to take a position as an emergency room physician at St. Elizabeth Hospital in Lafayette. He plans to devote more time to pastoral counseling with the Faith Baptist Counseling Service in Lafayette.

Bloodmobile Visit Honors Dr. Hill

At the June 30 visit of the Miami County Bloodmobile to Peru, Dr. Lloyd L. Hill was honored because of his support of the blood program since its beginning in 1969. For several years he assigned doctors to work at Bloodmobiles and he has been on call for every Bloodmobile visit since 1969.

Schedule for Upcoming NCME Programs

The Network for Continuing Medical Education announces the following schedule of programs:

Sept. 5-Sept. 18 "CLINICAL IMMUNOLOGY UPDATE"—The Mechanisms of Immune Competence;—Immune Deficiency Disorders;—Autoimmune Diseases. The telecourse faculty on this three-part program is Robert M. Nakamura, M.D., chairman, Department of Pathology, Scripps Clinic Medical Institutions, LaJolla, California, and Ernest S. Tucker, M.D., associate clinical professor of pathology and pediatrics, University of California School of Medicine, San Diego.

Sept. 19-Oct. 2 "THE NEPHROTOXICITY OF ANTIBIOTICS," with Harold C. Neu, M.D., professor of Medicine and Pharmacology, and head, Division of Infectious Diseases, Columbia University College of Physicians and Surgeons, New York.

"ANTIBIOTICS AND RENAL FAILURE," also with Harold C. Neu, M.D.

"THE INSULIN-DEPENDENT DIABETIC PATIENT: TWO UNSTABLE EPISODES," with Rubin Bressler, M.D., professor and head of Internal Medicine and professor of pharmacology, University of Arizona College of Medicine, Tucson.

Governor Bowen Lists Appointees

A number of physicians were included on the list of appointments and reappointments announced recently by Governor Otis R. Bowen.

Dr. William Bannon, Terre Haute, was reappointed to the Indiana State University Board of Trustees; Dr. Kenneth H. Bobb, Seymour, to the Madison State Hospital Advisory Committee; Dr. John H. Greist, Indianapolis, to the Larue D. Carter Hospital Advisory Committee; Dr. E. Blair Harter, Lafayette, to the State Soldiers Home Advisory Committee; Dr. Frank Green, Rushville, to the State Soldiers and Sailors Children's Home Advisory Committee; Dr. Richard Rahdert, Lafayette, to the Advisory Board to the Division on Child Mental Health; Dr. H. Carter Dunstone, Fort Wayne, to the Fort Wayne State Hospital Advisory Committee, and Dr. Warren Bergwall, Muncie, to the Richmond State Hospital Advisory Committee.

Additional appointees are Dr. John W. Beeler, Indianapolis, Indiana Protection and Advocacy for the Developmentally Disabled; Dr. Guy Ingwell, Knox, reappointed to a four-year term on the board of Norman E. Beatty Memorial Hospital, and Dr. Fred Daugherty, Crawfordsville, to the Board of Registration of Health Facility Administrators.

Spends Vacation as Medical Missionary

Dr. Amy Cheung, Indianapolis pediatrician, and her family spent two weeks in June in the Dominican Republic with the Medical Group Missions of the Christian Medical Society. Besides providing medical services, the mission conducted studies on the parasites that infest the natives and their surroundings.

Dr. DeLumpa Named Pediatric Fellow

Dr. Rustica C. DeLumpa, Valparaiso, was recently named a Fellow of the American Academy of Pediatrics.

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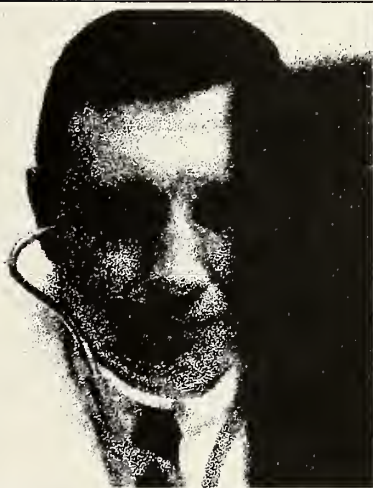
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Title	Date	AMA Category 1
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Radiology for the Primary Care Physician	9-14-77	6
Basic Immunology for the Practicing Physician	9-21-77	6
Epilepsy	9-30-77	6
Advanced Echocardiography	10-3-77 to 10-5-77	18
Care of the Critically Ill Child	10-5-77 to 10-6-77	12
Dermatology for the Primary Care Physician	10-13-77	6
Diabetes Update	10-15-77	6
Clinical Neuroophthalmology	10-19-77	6
Heart Disease—Review of Basics in Medical and Surgical Management	10-20-77	6
The Sick Child—Emotional Factors in Illness	11-9-77	6
Dermatology for the Practicing Physicians	11-9-77	6
Neonatal Workshop for Family Physicians	11-9-77 to 11-10-77	14
Clinical EEG for Neurologists	11-18-77	6
Contact Lens Seminar	11-19-77	6
Cardiopulmonary Workshop	12-7-77	6
Pulmonary Disorders—Modern Concepts	12-8-77	6
Office Orthopedics	12-14-77	6

For further information contact: Division of Postgraduate Medical Education, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46202; phone: (317) 264-8353.



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Dr. Benjamin Elected Ob-Gyn Fellow

Dr. Samson A. Benjamin, Crawfordsville, has been elected to Fellowship in the American College of Obstetricians and Gynecologists.

Legion of Honor Award to Dr. Donohue

Dr. John P. Donohue, professor and chairman of the Department of Urology, Indiana University School of Medicine, has been awarded the Legion of Honor of the Kidney Foundation of Indiana. The award is to express sincere appreciation for dedicated support of the Foundation's goals, to serve, to treat, to prevent, to cure.

Film on Hypercholesterolemia Offered

The Upjohn Company announces a new film "Hypercholesterolemia: A Major Risk Factor in Coronary Heart Disease." It is in full-color, sound, 16 mm, 23 minutes in length. It is available on a free loan basis. Write Upjohn at Kalamazoo giving name of film, date desired, alternate dates, and name and address.

Blood Pressure Report Offered

The Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure has just completed a Report which outlines a simple, economic approach to diagnosis and treatment. Copies of the "Joint National Committee Report" may be obtained by writing to the High Blood Pressure Information Center, 120/80 National Institutes of Health, Bethesda, MD 20014.

Sertoma Foundation Names Dr. Millan

Dr. Felix Millan, Munster, has been named a trustee of Sertoma Foundation. Sertoma is a men's service club with more than 900 clubs throughout the United States, Canada and Mexico. Dr. Millan is director of the Rehabilitation Team at St. Catherine Hospital, East Chicago.

Wins Mead Johnson Award

The 1977 Mead Johnson Award for Graduate Education in Family Practice was awarded to Dr. Edward L. Langston, Evansville, at the annual meeting of the Indiana Academy of Family Physicians in Indianapolis recently. Dr. Langston is currently a member of the housestaff at St. Mary's Hospital, Evansville.

He was one of 18 winners selected from a field of 150 candidates from all 50 states.

Doctors Serve as President, Chairman

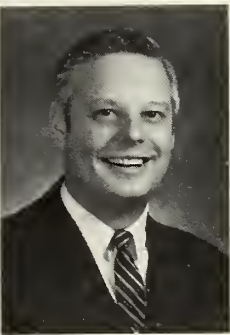
Butler University alumni recently elected Dr. B. T. Maxam, Indianapolis internist, president for 1977-78.

The search for a new president for the university is spearheaded by Dr. Max Norris, also an Indianapolis internist.

Dr. Herman Gick Oldest Bowler?

An item in *The Criterion* recently featured Dr. Herman H. Gick, Indianapolis, who was 90 years of age on May 22, and is believed to be the oldest active bowler in the Indianapolis area. He has been bowling regularly in the Knights of Columbus League for more than 50 years.

OCTOBER						
SUN	MON	TUE	WED	THU	FRI	SAT
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2	3	4	5	6	7	8
9	10 <small>Columbus Day</small>	11	12 <small>Traditional Columbus Day</small>	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
ISMA 1977 ANNUAL MEETING Hyatt Regency Hotel • Indianapolis						
30	31	NINETEEN SEVENTY-SEVEN				



TAX TIPS

LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

After the preparation of my July 1977 Tax Tips article, the Internal Revenue Service issued two tax forms, namely, a revised United States Gift Tax Return (Form 709, June 1977) and a New United States Estate Tax Return (Form 706, June 1977).

As to the gift tax form, the Internal Revenue Service has changed the form to follow my interpretation of §2523 and §2524, which I presented in my June 1977 article. That is, the Internal Revenue Service is no longer going to maintain the interpretation of the new law which the Internal Revenue Service presented on the United States Gift Tax Return (Form 709, February 1977). However, the new form still presents one problem of interpretation as to the amount which is to be inserted, in some cases, on line (h) (3) (b) of Schedule A. I have already presented my view concerning this matter in my June 1977 article. And, since the instructions to Form 709 are silent on the point involved, the Internal Revenue Service has, apparently, decided to delay publishing its interpretation until a later date. When the Internal Revenue Service interpretation is issued, I shall comment on it.

As to the new United States Estate Tax Return (Form 706, June 1977) I shall comment on it as I present my articles on the new estate tax law.

Both before and after the Tax Reform Act of 1976, §6075 provided that gift tax returns must be filed on or before the 15th day of the second month following the close of a particular calendar quarter. For example, if the quarter involved is the fourth calendar quarter (ending on December 31 of a particular year), then the gift tax return is due on or before the 15th day of February of the next year. Further, the Tax Reform Act of 1976 did not change the basic conditions for determining *whether* a gift tax return must be filed for a particular calendar quarter. These requirements are stated in §1019, and, in general, §1019 provides that a gift tax return must be filed whenever a donor makes a *gross* gift. That is, a donor must file a gift tax return whenever the donor makes a gift of a present interest in excess of the \$3,000 annual exclusion or makes a gift of a future interest of \$1 or more.

However, the Tax Reform Act of 1976 did change the method for determining the calendar quarter upon which the gift tax return's due date is measured (that is, the calendar quarter after which the "15th day of the second month" period begins). Specifically, for calendar quarters which begin after 1976, gift tax returns must be filed on or before the 15th day after the earlier of: the calendar quarter in which the donor's total *unreported taxable* gifts exceed \$25,000; and, the fourth calendar quarter of the year during which the donor makes a gross gift.

Therefore, the rule continues to be that—if, for any calendar year, a donor does not make a gift of a present interest in excess of \$3,000 nor a gift of a future interest of \$1 or more, then the donor does not have to file a gift tax return for that calendar year. And, the rule continues to be that—if, during a particular calendar quarter, a donor does make a gross gift, then the donor must file a gift tax return for that quarter. However, in the latter event, the new law provides that so long as the donor's total *unreported taxable* gifts (that is, the total

amount of the donor's gifts which remain after taking into account any: gift splitting; exclusions; and, deductions) do not exceed \$25,000, then the donor need not file the gift tax return until the February 15th which follows the close of the calendar year during which the gross gift is made. On the other hand, the new law provides that if, at the close of the particular quarter, the donor's *unreported taxable* gifts are in excess of \$25,000, then the donor must file a gift tax return for the particular quarter involved, on or before the 15th day of the second month which follows the close of such quarter.

A simple example will illustrate the operation of the new rule. Assume that a donor makes (after taking into account any election to split gifts, and after utilizing all exclusions and deductions) taxable gifts of up to \$25,000 during the first quarter of 1977. Obviously, the donor must file a gift tax return for the first quarter of 1977, because the donor has made a gross gift during that quarter. This was the rule prior to 1977 and it is still the rule after 1976. However, if the donor makes no other gifts during 1977, then the donor does not have to file the gift tax return until Feb. 15, 1978, which is the 15th day of the second month which follows the close of the calendar year in which the gift is made. Similarly, if a donor makes taxable gifts of no more than \$25,000 during any one of the other three quarters during the year (that is, a total of no more than \$25,000 of taxable gifts for the entire calendar year), then the donor need not file a gift tax return until February 15th of the year which follows the year during which these gifts are made.

On the other hand, if a donor makes, for example, *taxable* gifts of \$20,000 during the first quarter of 1977, and, for example, *taxable* gifts of \$20,000 during the second quarter of 1977, then, because the *unreported taxable* gifts exceed \$25,000 at the end of the second quarter, the donor must file a gift tax return on or before the 15th day of the second month which fol-

lows the close of such second quarter—namely, on or before Aug. 15, 1977.

Now, assume that this latter donor makes *taxable* gifts of \$20,000 during the third quarter of 1977, in addition to the prior two gifts of \$20,000 each. As to the latter gifts, no gift tax return is due until Feb. 15, 1978, because (assuming that there are no additional gifts during the fourth quarter of 1977), the donor does not have *unreported* taxable gifts in excess of \$25,000 for the third and fourth quarters of 1977.

Obviously, these new procedural rules will decrease the number of filings of gift tax returns, because donors may now “accumulate” small gifts and report all of the gifts on one gift tax return, which may be filed after the end of the fourth quarter of the calendar year involved, instead of filing one gift tax return for *each* quarter in which the donor makes a gross gift. In addition, the new rules will eliminate, in certain cases, the so-called “small gifts” problem. This latter problem (or inequitable result) arose under the prior law whenever a donor made total gifts to the donor’s spouse of under \$12,000 during *two* or more quarters of a calendar year—as opposed to making *one* gift (of the entire amount) in *one* calendar quarter.

For example, assume that prior to 1977 a donor made a gift (of a present interest to the donor’s spouse) of \$5,000 during one quarter of a calendar year, and then, made a gift (of a present interest to the donor’s spouse) of \$5,000 during another quarter of the same calendar year. In this case, the donor’s marital deduction for the first quarter would be \$2,000 (50% of \$5,000 equals \$2,500, but the deduction is limited by §2524 to the amount of the gross gifts made to the spouse of \$2,000—namely, to \$5,000 less the exclusion of \$3,000). As to the second quarter, the donor’s marital deduction is \$2,-

500 (50% of \$5,000); because the donor would not be entitled to a second \$3,000 exclusion for the second gift to the donor’s spouse during the same calendar year.

On the other hand, if the donor had made only *one* gift of \$10,000 (of a present interest to the donor’s spouse) during one quarter of that calendar year, then the donor’s marital deduction for the calendar year, would have been \$5,000, because the “gross gifts” limitation of §2524 would not be applicable (\$10,000 less \$3,000 equals \$7,000, and the marital deduction under the general rule is only \$5,000).

Clearly, the Tax Reform Act of 1976 should have eliminated this inequity—in which a donor can pay less gift tax (if the donor makes a single gift to the donor’s spouse in one quarter of a year) than the donor would pay (if the donor makes two or more gifts to the donor’s spouse in two or more quarters of the year). Unfortunately, however, the small gifts problem still exists, in certain cases, after the donor has given the donor’s spouse gifts in excess of \$200,000.

The effect of the new law on the “small gifts” problem is as follows: If a donor makes gifts to the donor’s spouse, which gifts do not exceed the available exclusions plus \$100,000, then the donor will not be liable for any gift tax, because, in most situations, the donor is entitled to a marital deduction of up to \$100,000 for such gifts. And, if the donor makes gifts in excess of the available exclusions and the first \$100,000 base, then the donor is taxable on the second \$100,000 of gifts which the donor makes to the donor’s spouse. And, once the donor makes gifts to the donor’s spouse which are in excess of the available exclusions plus \$200,000, then the small gifts problem will generally be eliminated because of the requirement that the donor does not have to file a gift tax return until: the donor has unre-

ported taxable gifts of \$25,000, or the calendar year ends. That is, the “small gifts” problem will never arise in a situation in which all the gifts (which are made in two or more quarters) are reported on one gift tax return.

However, the small gifts problem can still occur in situations in which: the donor has made gifts to the donor’s spouse in excess of the exclusions plus \$200,000, and then the donor makes small gifts (of present interests to the donor’s spouse) in two or more quarters, along with gifts to another person, so that the total of the donor’s gifts for *each* quarter require the filing of a gift tax return for *each* quarter. For example, assume that the donor (who has made gifts in excess of the available exclusions and \$200,000 in prior years) makes a gift of \$5,000 (of a present interest) to the donor’s spouse, and, during the same quarter, the donor makes a gift of \$24,000 to another person. Under the new law, the donor is entitled to a marital deduction of \$2,000 (after applying the limitation in §2524) and the donor must file a gift tax return for this quarter, because the donor has made unreported taxable gifts in excess of \$25,000. And, if the donor makes gifts of the same amounts to the same persons during a later quarter in the same calendar year, then the donor’s marital deduction for the latter quarter is \$2,500 (50% of \$5,000), and the donor must file a gift tax return for the latter quarter because the donor has unreported taxable gifts in excess of \$25,000 for the latter quarter. Thus, under these facts, the donor’s total marital deduction is \$4,500 (\$2,000 plus \$2,500).

On the other hand, if this donor had made, in this year, one gift of \$10,000 to the donor’s spouse in one quarter and a gift of, for example, \$50,000, to the other individual in the same quarter, then the donor is entitled to a total marital deduction of \$5,000 (50% of \$10,000) for this quarter. ◀



Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

- **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.
- **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.
- **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg/kg/day in rabbits and 10 mg/kg/day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children. Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy. See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG *Pfizer*
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert[®]/25 
(meclizine HCl) 25 mg. Tablets
for vertigo*

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So learn a skill you can play for life.



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TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE **DYAZIDE®**

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

Warning

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions:

Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions;

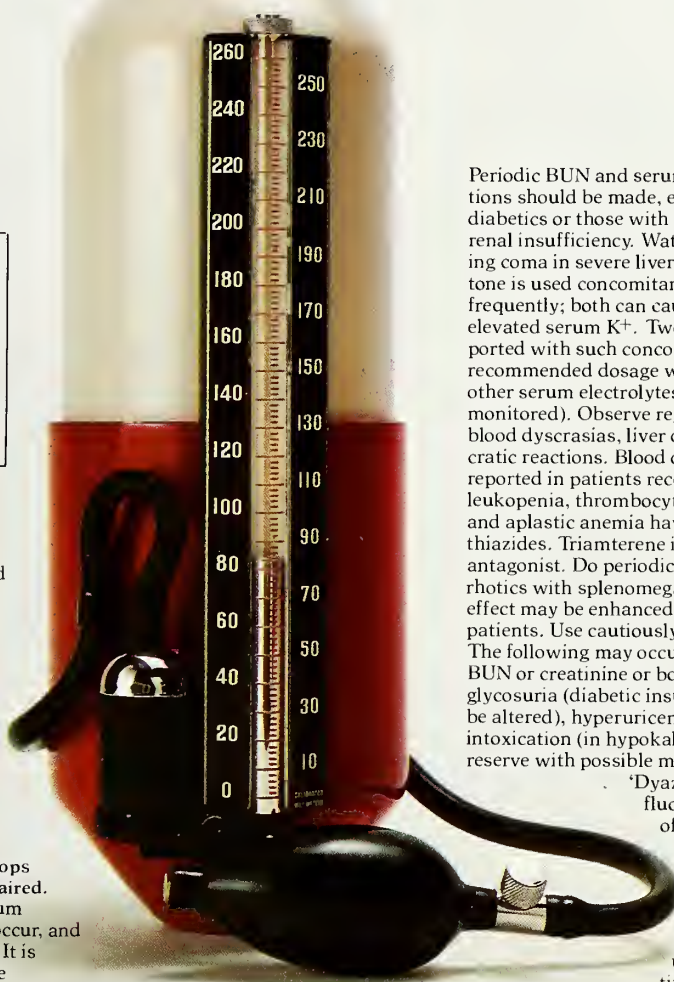
nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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OF HYPERTENSION*
SERUM K⁺ AND BUN SHOULD
BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)**

SK&F CO., Carolina, P.R. 00630

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EMPRACET® with Codeine Phosphate, 60 mg, No. 4 ©

EMPRACET® with Codeine Phosphate, 30 mg, No. 3 ©

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or codeine.

WARNINGS: Drug dependence. Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act **Usage in ambulatory patients.** Caution patients that these products may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

PRECAUTIONS: Head injury and increased intracranial pressure. Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. These products or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to certain patients such as elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS: Most frequently include lightheadedness, dizziness, sedation, nausea, and vomiting, more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; others include: euphoria, dysphoria, constipation and pruritus.

DRUG INTERACTIONS: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.

Introducing **EMPRACET®** **ċ CODEINE #4**

Each tablet contains: codeine phosphate, 60 mg (1 gr) (Warning—may be habit-forming); and acetaminophen, 300 mg



Our new non-aspirin/ codeine analgesic for moderate to severe pain.

New peach-colored Empracet ċ Codeine #4 offers a potent alternative for patients in whom aspirin is not indicated.

Unlike compounds containing oxycodone which afford comparable analgesia, new Empracet ċ Codeine #4 gives you CIII prescribing convenience—up to 5 refills in 6 months at your discretion (where state law permits). And, prescribing by telephone is permissible in most states. Moreover, new Empracet ċ Codeine #4 has less addiction potential than does oxycodone.

For those of your patients requiring a less potent analgesic, non-aspirin Empracet® ċ Codeine #3 provides effective relief of moderate pain.

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What's New?

Sterile Plastics Corporation has a new kit for the collection and dry transport of throat swab specimens from patients suspected of having Beta Hemolytic Streptococci infections. The kit consists of a sterile Dacron® swab on a flexible plastic stick, a foil pouch containing silica gel desiccant crystals and a swab transport envelope with a report form. The dessicant crystals function as a fast dryer to improve survival of streptococci and to kill some other bacteria which might impede their detection.

Cromolyn sodium, which has been distributed in the U.S. under the trade name "Aarane," will be distributed in the future by Fisons, which will also market cromolyn sodium under its brand name of "Intal."

Control-o-fax Office Systems has introduced a new collection envelope for professional offices. It is known as "The Early-Payment" Envelope and is designed to encourage payment by patients at time of visit or before regular statement is sent. It features a detachable appointment Slip.

Maclevy Products is agent in this country for an exercise bicycle which is manufactured in Finland. The stationary cycle is the first to be equipped with an ergometer which accurately measures the work done and allows the patient to accomplish a progressive exercise program. The device is called the "Tunturi Ergometer Training Cycle."

Fyrnetics has a self-contained, battery-operated, early warning ionization smoke alarm for residential use. It operates on one inexpensive 9 volt alkaline battery and detects both visible and invisible combustion particles. It features a test button and when the battery needs replacement it emits a "chirp" every 30 seconds for up to one month.

Parker Publishing has published "Pain-Free Living: How to Prevent and Eliminate Pain All Over the Body." The author is Howard Hirschhorn, a medical and technical writing consultant. He reports on effective remedies for relief from miseries of toothaches, sore gums, eye-strain, headache, sinus attacks, allergies, stings, indigestion and fatigue. 204 pages, \$9.95.

Travenol Laboratories has a new 20 micron transfusion filter which removes clots and microaggregates and also allows rapid flow rates. The large surface area of the filter allows filtering capacity for multiple transfusions. The filter is designated "Fenwal® 20 Micron High Capacity Transfusion Filter."

Maico Hearing Instruments announces three new behind-the-ear hearing aids. One is designed to elimi-

nate feedback when volume is advanced to high levels. Another is the directional version of the first. The third newcomer is a high power, high gain instrument intended for moderate to severe hearing impairments.

Mediscience Technology has developed the 100CER Cardiac Event Recorder which gives the advantages of a 24-hour continuous tape recorder by recording only the significant runs. Only abnormalities trigger the continuous tape, which can be replayed at will. The device weighs less than two pounds and can be comfortably worn at the waist.

Hub States Corporation announces a convenient, easy to use, spray type insecticide package called "Tower of Power." The insecticide is non-toxic to humans and may be used around food stuffs when applied according to directions. It contains no oil or harmful gases. There is no fire or explosion hazard.

Eaton Laboratories announces a new directory of medical films, audio-visuals and medical education resources, available from Eaton. Copies of the 90-page book, which describes Eaton's 16 mm films, 35 mm slide programs, speakers and publications, may be obtained from an Eaton representative or by writing to Eaton at Norwich, N.Y. 13815. There are 191 full-color, sound films listed. This includes 10 new films which will be available this summer and fall, for the first time.



The Auxiliary Reports to ISMA



Three Area Workshops held in June at Plymouth, Spring Mill and Indianapolis for county presidents, community health, AMERF, project bank and legislative included a mini course on parliamentary procedures, a demonstration of CPR and two speakers, the Reverend Lanis Twyman and Mrs. James Woods. Everyone returned home with renewed enthusiasm and ideas. And it was a very rewarding experience for me to be able to personally meet the county officers from all over the state. A survey showed the counties want to continue the workshop in the three areas but prefer to have it in May.

We had nine delegates to the AMAA convention in San Francisco: Mrs. Ruth Martin, Trudy Mudd, Lois Walker, Phyllis Schmidt, Ruth Gattman, Wilma Jean Scamahorn, Vivian Priddy, Dorothy Bickers and Mary K. Stanley. Also, Presidential Delegate Chloe Goldsmith and National Officer Marge Smith. We also had three alternates in attendance: Barbara Lukemeyer, Marilyn Lahr and Norma Baluyut.

Mrs. Gardner's report, as well as the state reports, did prove "we can make a difference" with our projects. She encouraged the state presidents and others attending to work more closely with the county presidents, **because this is the strength of our Auxiliary.**

I would also like to stress this: Dr. Palmer asked for the Auxiliary's assistance this fall with the AMA's new public service program on immunization. They will have mass media involvement, with TV ads for children, radio spots and prepared kits for newspapers. But this will all be done by the Auxiliary. We are pleased to have the opportunity to serve in this capacity.

Mrs. Chester Young, our new AMAA president, quoted from Robert Louis Stevenson's "Achievement." She said "We need to talk and think values as they affect us. Today I would like you to think with me about values in terms of making choices, sharing goals and having long range vision. We have values because we care about what happens to people."

The Auxiliary gave more than One Million Dollars to AMERF again this year.

A large, elegant handwritten signature in cursive script that reads "Mary K. Stanley".

Mary K. (Mrs. John R.) Stanley
President, ISMA Auxiliary

INDIANA MEDICAL BUREAU

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Deaths

Francis M. Fargher, M.D.

Dr. Francis M. Fargher, Michigan City, died June 7 in St. Margaret's Hospital, Hammond. He was 69.

Following graduation from the Indiana University School of Medicine in 1932, Dr. Fargher interned at Methodist Hospital, Indianapolis, and opened his office in Michigan City the following year, retiring in 1974.

He served as president of the medical staff of St. Anthony Hospital and was a member of the LaPorte County Medical Society and the American Medical Association.

Clyde M. Fish, M.D.

Dr. Clyde Monroe Fish, former South Bend physician, died in a Grand Rapids, Mich., health center July 19. He was 87.

He obtained his M.D. degree from the Chicago College of Medicine and Surgery in 1910 and retired in 1960.

Dr. Fish was a Fellow of the International Proctological Society, of which he had served as vice president, and he was a member of the St. Joseph County Medical Society and the American Medical Association. A Senior Member of the Indiana State Medical Association, Dr. Fish became a member of the 50-Year Club in 1960.

Jacob C. Fleischer, M.D.

Dr. Jacob C. Fleischer, retired East Chicago physician, died in St. Catherine Hospital, East Chicago, June 27. He was 65.

A 1937 graduate of the University of Illinois Medical School, Dr. Fleischer was in the practice of general medicine

and surgery at East Chicago for nearly 40 years, retiring two years ago.

Dr. Fleischer served on the Indiana State Medical Association's Commission on Public Health from 1963 to 1966.

In addition to membership in the Lake County Medical Society and the American Medical Association, he was a member of the International College of Surgeons.

William Harlan, M.D.

Dr. William Lee Harlan, 53, Evansville neurologist, died at his home on July 4.

A graduate of the Indiana University School of Medicine with the Class of 1947, he practiced at Ligonier for a number of years following an internship at Grace Hospital, Detroit. He was a resident at the Mayo Foundation, following which he practiced in Evansville. He also was on the faculty of Creighton University, Omaha for a time, returning to Evansville in 1975.

Dr. Harlan was certified by the American Board of Psychiatry and Neurology and was a member of the American Academy of Neurology.

He was also a member of the Vanderburgh County Medical Society, and the American Medical Association.

Edwin L. Libbert, M.D.

Dr. Edwin L. Libbert, 77, Columbus, died June 7 in the Bartholomew County Hospital.

Formerly chief of the department of radiology at the West 10th Street Veterans Administration Hospital in Indianapolis, Dr. Libbert was on the staff of Bartholomew County Hospital until his retirement four years ago.

He was a 1924 graduate of the Indiana University School of Medicine and interned at Methodist Hospital, later practicing at Dillsboro. He served with the Army Medical Corps in World War II.

A diplomate of the American Board of Radiology, Dr. Libbert was a Senior Member of the Indiana State Medical Association and a member of its 50-Year Club. He was a member of the Bartholomew-Brown County Medical Society and was formerly a member of the American Medical Association.

Russell Mathewson, M.D.

Dr. Russell C. Mathewson, Muncie psychiatrist, died July 2 in Ball Memorial Hospital. He was 67.

He received his M.D. degree from Marquette University in 1944 and interned at Milwaukee County Hospital. He served with the U. S. Army in World War II. Following the war he served a psychiatric residency at the Veterans Administration Hospital in Boston, did postgraduate work at Columbia University and, for three years, served as chief of the New Orleans VA Mental Health Outpatient Clinic. He was also on the staff at Mississippi State Hospital at Whitfield for three years. Dr. Mathewson was a psychiatrist at the Muncie Clinic from 1956 until 1961 and had a private practice in Muncie until his retirement in 1975.

Dr. Mathewson was consultant for the Family Service Association for 20 years.

A member of the Delaware-Blackford County Medical Society, he was a diplomate of the American Board of Psychiatry and Neurology and was also a member of the American Medical Association.

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128th

Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

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*Complete Program and
Annual Reports on
Following Pages*

CONVENTION SECTION

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Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Hyatt Regency Hotel, Indianapolis, Oct. 23, 24, 25 and 26, 1977.

The House of Delegates will be constituted as follows: Marion County, twenty-four delegates; Lake County, ten delegates; Allen County, seven delegates; Vanderburgh County, six delegates; St. Joseph County, five delegates; Delaware-Blackford, Owen-Monroe, Tippecanoe and Wayne-Union county societies, each three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Grant, Harrison-Crawford, Howard, Jefferson-Switzerland, LaPorte, Madison, Parke-Vermillion, Porter and Vigo county societies each two delegates; the other 57 county societies, each one delegate; fourteen trustees and the ex-presidents—namely, Herman M. Baker, M. C. Topping, Kenneth L. Olson, Earl W. Mericle, Guy A. Owsley, Maurice E. Glock, Donald E. Wood, Joseph M. Black, Eugene S. Rifner, Patrick J. V. Corcoran, Lowell H. Steen, Malcolm O. Scamahorn, Peter R. Petrich, James H. Gosman, Joe Dukes, Gilbert M. Wilhelmus and Vincent J. Santare. The American Medical Student Association, one delegate. The delegate or their designated alternate delegate elected by their respective section shall also be a member but without power to vote. The following shall be ex officio members; the president, president-elect, the executive director, the treasurer, the assistant treasurer, the speaker, the vice-speaker and the delegates to the American Medical Association, all without power to vote, except in the case of a tie vote, when the speaker or person presiding shall cast the deciding vote.

All delegates must present their credentials card certified by their county medical society before being seated as a delegate. No delegate will be seated without proper certification.

The House of Delegates will convene promptly at 3 p.m., EST, Sun., Oct. 23, in the Hyatt Regency Hotel, Indianapolis. The final meeting of the House of Delegates will convene at 9 a.m., Wed., Oct. 26, in the Hyatt Regency Hotel.

The order of business will be as follows:

1. Call to order by the President.
2. Invocation.
3. Roll call and seating of qualified delegates.
4. Announcements from the chair.
5. Tribute to members of the House or those who served the association in an official capacity and who have died since the 1976 session.
6. Reading of minutes of previous meetings.
7. Introduction of guests.
8. President's address.
9. Appointment of Reference Committees and assignment of meeting rooms.
10. Unfinished business
11. Address of president-elect.
12. Report of president of the ISMA Auxiliary.
13. Report of the Indiana Chapter, American Medical Student Association.
14. Report of president of Blue Shield.
15. Report of executive director.
16. Report of treasurer.
17. Report of chairman of the Board.

A. Reports of Actions of the Board of Trustees

18. Report of trustees
19. Report of *The Journal* editor.
20. Report of AMA delegates.
21. Report of Indiana Medical Licensing Board.
22. Ad Hoc Committee to Supervise Pilot Project on Medical and Health Care in Jails.
23. Ad Hoc Committee on Arbitration.
24. Ad Hoc Committee on the Impaired Physician.
25. Reports of committees and commissions.

COMMITTEES

- (1) Executive
- (2) Grievance
- (3) Future Planning
- (4) Medical-Legal

COMMISSIONS

- (1) Commission on Constitution and Bylaws
 - (2) Commission on Convention Arrangements
 - (3) Commission on Legislation
 - (4) Commission on Medical Education
 - (5) Commission on Medical Services
 - (6) Commission on Public Relations
26. New Business:
- (1) Matters referred by Board of Trustees
 - (2) Matters referred by Executive Committee
 - (3) Resolutions
 - (4) Selection of city for 1982 meeting
- 1978—French Lick—October 14-19
1979—Indianapolis—October 8-10
1980—Indianapolis—dates to be set by the Board of Trustees
1981—Indianapolis—dates to be set by the Board of Trustees

The election of officers will be the first order of business at the final meeting of the House of Delegates. In addition to the regular officers, the terms of the following AMA delegates and alternates expire Dec. 31, 1977, and their successors must be elected at the session: Delegates to the American Medical Association to succeed Patrick J. V. Corcoran, Evansville and Peter R. Petrich, Attica; alternate delegates to succeed Thomas C. Tyrrell, Hammond, and Marvin E. Priddy, Fort Wayne.

Delegates from the First, Fourth, Seventh, Tenth and Thirteenth districts are reminded that the terms of their trustees will expire Oct. 26, 1977, and new trustees should be elected to succeed the following:

- First—Bernard B. Rosenblatt, Evansville
Fourth—Howard C. Jackson, Madison
Seventh—John O. Butler, Indianapolis
Tenth—Martin J. O'Neill, Valparaiso
Thirteenth—G. Beach Gattman, Elkhart

Some of these elections may already have been held, but they should be reported to the House of Delegates at this session for confirmation.

DONALD F. FOY, Executive Director

HOUSE OF DELEGATES

1977 Annual Meeting Indiana State Medical Association

County and Delegates	Alternates	County and Delegates	Alternates
ADAMS (1) Norval S. Rich Decatur	Harold Zwick Decatur	DECATUR (1) Gene Gebele Greensburg	Robert Acher Greensburg
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BARTHOLOMEW-BROWN (2) C. David Ryan Columbus Robert M. Seibel Nashville	Lindley L. Gammell Columbus	DELAWARE-BLACKFORD (3) Warren L. Bergwall Muncie Donald W. Hunsberger Montpelier Ross L. Egger Daleville	Larry Cole Yorktown Herbert W. Berner Muncie Serverino T. Sulit Hartford City
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BOONE (1) Paul R. Honan Lebanon	Ritchie Coons Lebanon	ELKHART (2) Willard Krabill Goshen James R. Miller Wakarusa	Donald Minter Goshen John Collins Elkhart
CARROLL (1) T. Neal Petry Delphi	Charles L. Wise Camden	FAYETTE-FRANKLIN (2) William F. Kerrigan Connersville Perry F. Seal Brookville	John M. Lockhart Connersville Noli C. Guinigundo Brookville
CASS (1) Richard L. Glendening Logansport	Joseph A. Frederick Logansport	FLOYD (1) Everett E. Bickers Floyds Knobs	William V. Johnson New Albany
CLARK (1) David Jones Charlestown	William Voskuhl Charlestown	FOUNTAIN-WARREN (2) Max N. Hoffman Covington A. S. Salvo Williamsport	Lowell R. Stephens Covington Carl A. Nelson West Lebanon
CLAY (1) Robert Oehler Brazil	Everett L. Conrad Brazil	FULTON (1) Joseph D. Richardson Rochester	Pedro G. Del Rosario Rochester
CLINTON (1) Lee F. Dupler Frankfort	Charles E. Bush Frankfort	GIBSON (1) Don Pruitt Evansville	William Dye Oakland City
DAVIESS-MARTIN (2) Robert H. Rang Washington Robert E. Chattin Loogootee	H. O. Norton Washington Brisco E. Lett Loogootee	GRANT (2) Robert Brown Marion Herbert Khalouf Marion	Shirley Khalouf Marion Charles R. Kershner Marion
DEARBORN-OHIO (2) Henry W. Conrad Lawrenceburg Gordon Fessler Rising Sun	Ivan T. Lindgren Aurora	GREENE (1) William R. Powers Lyons	Carl H. Porter Jasonville
		HAMILTON (1) A. Adrian Lanning Noblesville	Joe R. Lloyd Noblesville

HOUSE OF DELEGATES

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JASPER (1) Kenneth J. Ahler Rensselaer	P. A. Williams Rensselaer		
JAY (1) James S. Fitzpatrick Portland	Ralph Schenck Portland		
JEFFERSON-SWITZERLAND (2) Ott B. McAtee Madison Diego C. Valenzuela Vevay	Robert Zink Madison G. E. Blair Vevay		
JENNINGS (1) James Calli, Sr. North Vernon	Mark P. Yeager North Vernon		
JOHNSON (1) M. M. Wesemann Franklin	Joseph Young Greenwood		
KNOX (1) Frederick H. Buehl Vincennes	Norbert M. Welch Vincennes		
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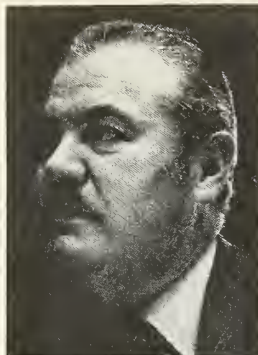
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1976-1977



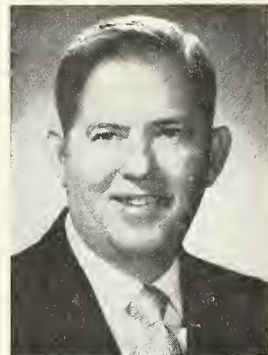
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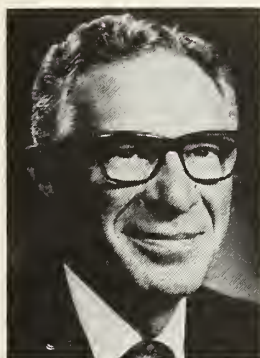
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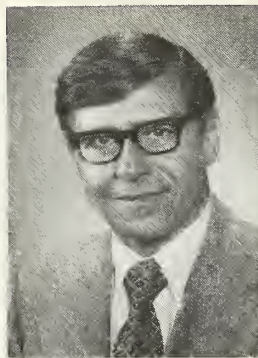
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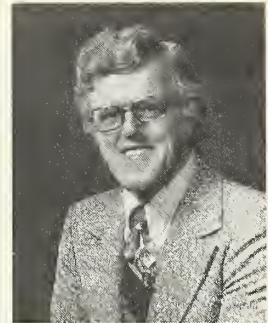
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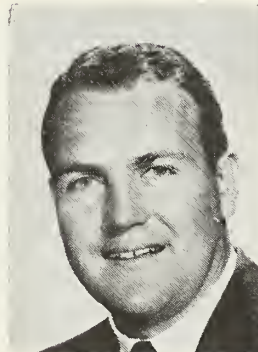
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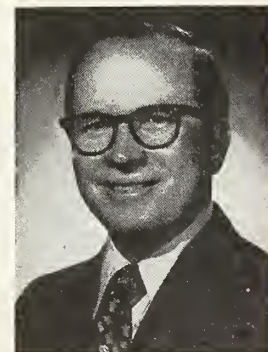
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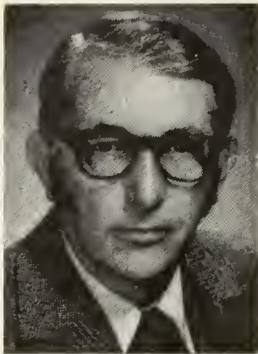


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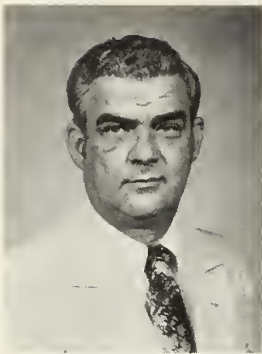
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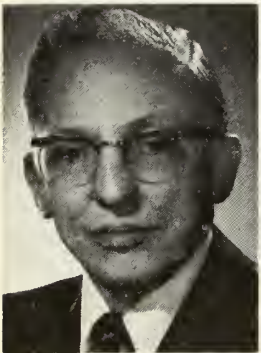
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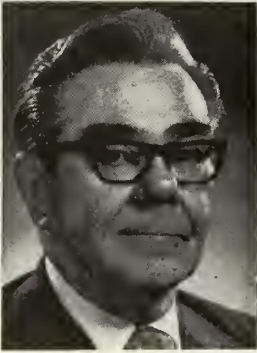
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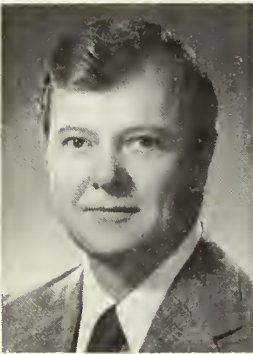
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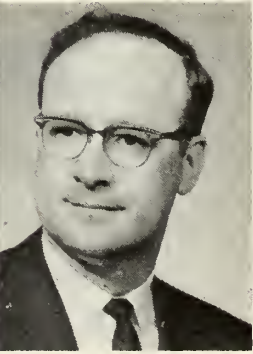
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A. W. CAVINS, M.D.
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Terre Haute



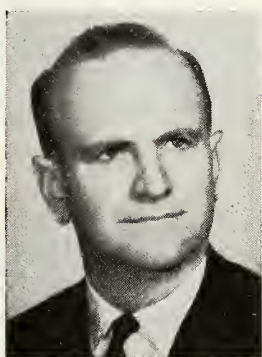
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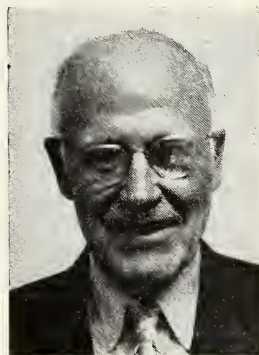
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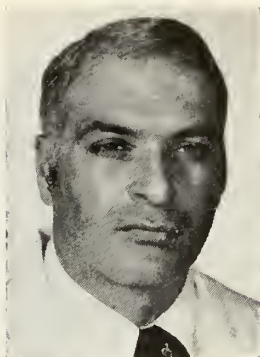


RODNEY A. MANNION, M.D.
Editorial Board
LaPorte

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Surgery

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Indianapolis

VICE-CHAIRMEN

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Sullivan

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DOUGLAS H. WHITE, M.D.
Indianapolis



CHARLES W. MAGNUSON,
M.D.
South Bend

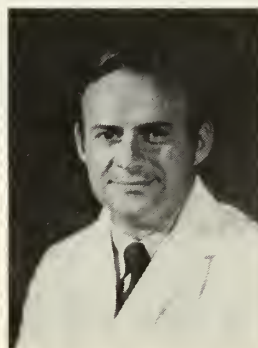


WILLIAM BASTNAGEL, M.D.
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Ophthalmology and Otolaryngology



JOHN BIZAL, M.D.
Evansville



EUGENE HELVESTON, M.D.
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DANIEL R. EVANS, M.D.
Valparaiso

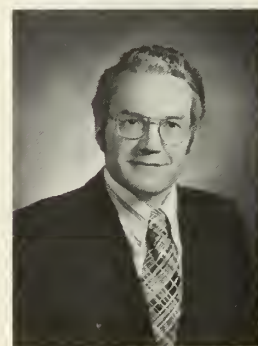
Anesthesiology

NO
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NORMAND TOWNLEY, M.D.
Indianapolis

NO
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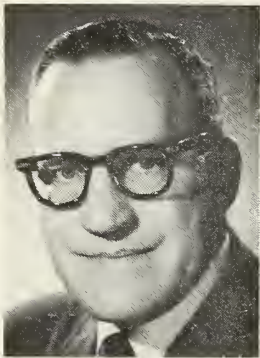
ROBERT LONGSHORE, M.D.
Kokomo



WENDELL EDWARDS, M.D.
Indianapolis

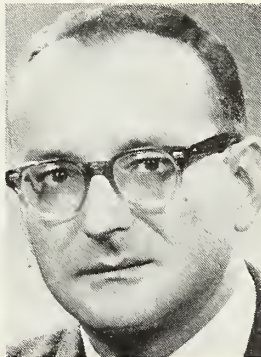
Family Physicians

CHAIRMEN



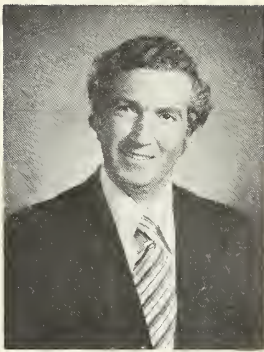
WILLIAM T. LEFFLER, M.D.
Indianapolis

VICE-CHAIRMEN



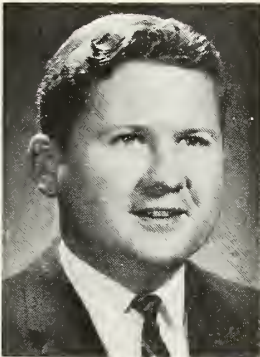
HANS E. GEISLER, M.D.
Indianapolis

SECRETARIES

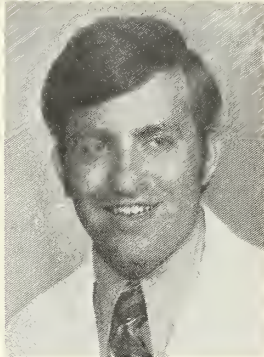


HARVEY HIMELSTEIN, M.D.
Indianapolis

Obstetrics
and
Gynecology



JAMES L. MOUNT, M.D.
Bedford

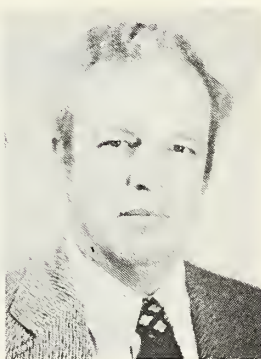


PAUL JARRETT, M.D.
Indianapolis

Public Health
and
Preventive Medicine



IVAN T. LINDGREN, M.D.
Aurora



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M.D.
Jeffersonville

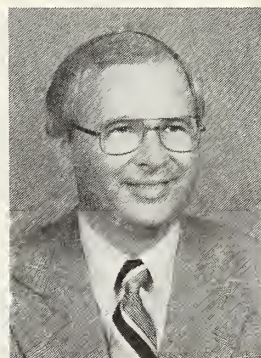


DAVID EDWARDS, M.D.
Indianapolis

Radiology



EDWIN F. KOCH, JR., M.D.
Muncie



WILLIAM J. MILLER, M.D.
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**Nervous and
Mental Diseases**

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**RICHARD N. FRENCH, JR.,
M.D.
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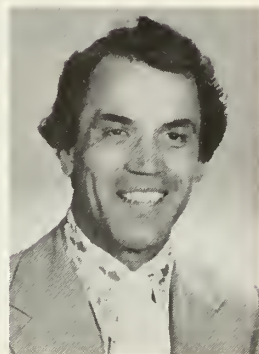
**JEFFREY J. KELLAMS, M.D.
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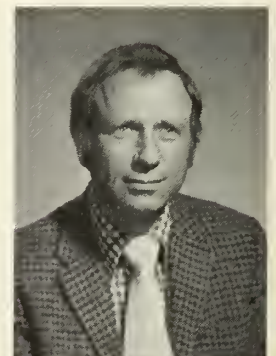
**Directors of
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**W. THOMAS SPAIN, M.D.
Evansville**



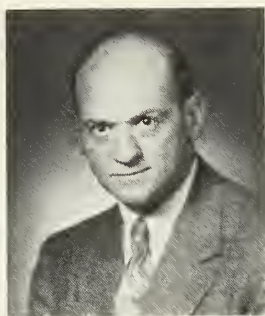
**BARBARA BACKER, M.D.
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**ROBERT D. ROBINSON, JR., M.D.
Indianapolis**

Cutaneous Medicine

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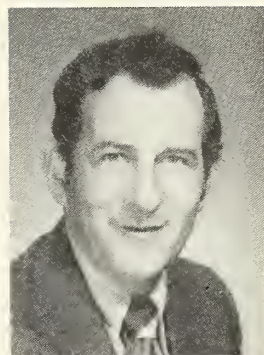
EMANUEL C. LISS, M.D.
South Bend

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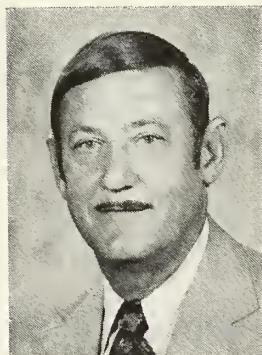
EDWARD L. PROBST, M.D.
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SECRETARIES



WILLIAM J. CRON, M.D.
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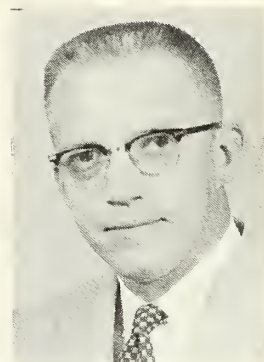
Allergy



WILLIAM MOUNT, M.D.
Lafayette

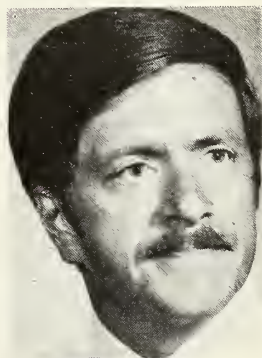


HOWARD R. MARVEL, M.D.
Lafayette



BEAUFORT A. SPENCER,
M.D.
Bloomington

Urology

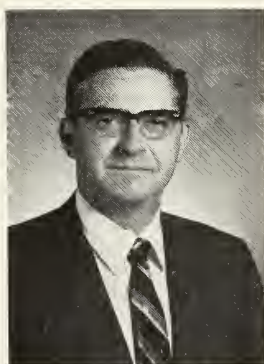


RUSSELL L. JUDD, M.D.
Indianapolis

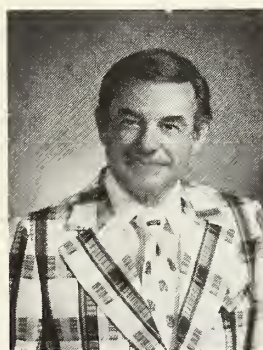


DAVID SCHLUETER, M.D.
Fort Wayne

Orthopedic Surgery



ROBERT F. KIMBROUGH, M.D.
Fort Wayne



FRANK THROOP, M.D.
Indianapolis



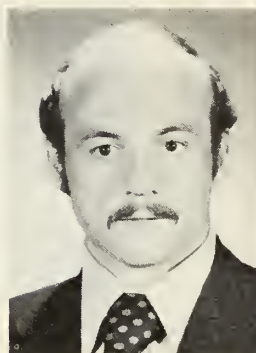
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C. David Ryan, Columbus (Bartholomew-Brown)

Schedule of Events—128th Annual Convention

Hyatt Regency

Washington at Illinois Street
Indianapolis

(All Events will be on Eastern Standard Time)

(The scientific program for the 128th Annual Convention of the Indiana State Medical Association is acceptable for 13 prescribed hours by the American Academy of Family Physicians. The prescribed hours are for attendance at the Family Physicians Section meeting. Elective hours approved for attendance at section meetings other than Family Practice.)

(Scientific programs presented at the 1977 ISMA Convention are accredited on an hour-for-hour basis for inclusion in Category 1 of the application for the AMA Physician's Recognition Award. Hours allowable in any given program are shown beside the program listing.)

Saturday, Oct. 22, 1977

7:00 p.m. Board of Trustees Annual Dinner—
Canyon Hall (second floor)

Sunday, Oct. 23, 1977

9:00 a.m. Registration Begins
Opening of Scientific Exhibits

9:00 a.m. PRACTICE MANAGEMENT PRO-
to GRAM, presented by Clayton L. Scrog-
gins Association, Cincinnati—Canyon
4:00 p.m. Hall (second floor)

Indiana Society of American Association of Medical Assistants

Regency A (second floor)

9:00 a.m. Registration—Compliments of ISMA
THE MEDICAL ASSISTANT'S ROLE
IN PROMOTING HEALTH CARE

10:00 a.m. —CHILDHOOD DISEASES, Robert L.
to Parr, M.D., Indianapolis

10:30 a.m.

10:30 a.m. —VENEREAL DISEASE, Charles Bar-
to rett, M.D., Indiana State Board of Health,
11:00 a.m. Indianapolis

11:00 a.m. —HEPATITIS, John C. Lowe, M.D.,
to Indianapolis

11:30 a.m.

12:00 Lunch Break—On Your Own
to

1:00 p.m.

1:00 p.m. PARENT-NEWBORN BONDING,
to Patricia Keener, M.D. Community Hos-
2:00 p.m. pital, Indianapolis
New Emphasis on Family Unity

2:15 p.m. CHANGING UNDESIRABLE HABITS
to TO DESIRABLE HABITS

3:30 p.m. Use of Behavior Modification Technics
in Personal and Professional Life, e.g.,
Overeating, Smoking, Mr. Richard Smith,
Buchanon Counseling Center, Methodist
Hospital, Indianapolis

10:00 a.m. ISMA Executive Committee Meeting—
Yellowstone and Everglades (second floor)

Section on Radiology and Indiana Roentgen Society Yosemite and Sequoia (second floor) (Possible Hours of Accreditation 1.0)

10:00 a.m. Executive Committee Meeting, Indiana
Roentgen Society

11:00 a.m. General Meeting

12 Noon Luncheon

1:00 p.m. THE IMPACT OF NEW MEDICAL
DEVICE LEGISLATION ON THE
PRACTICE OF RADIOLOGY, Ross S.
Jennings, Vice President, Cook Inc.
Election of 1978 Section Officers

SPEAKER

ROSS S. JENNINGS
Blaamington

Mr. Jennings is vice-president of Cook, Inc., Bloomington. A graduate of the University of Texas, he was formerly a research assistant with the Department of Medicine (Cardiology), I.U. Medical Center, Indianapolis.



Sunday, Oct. 23, 1977

**Section on Directors of Medical Education and
Association of Indiana Directors of Medical Education**

Well House (third floor)
(Possible Hours of Accreditation 2.0)

- 12 Noon Luncheon
- 1:00 p.m. to 3:00 p.m. MEDICAL AUDIT OF INFECTIOUS DISEASE, Calvin M. Kunin, M.D., University of Wisconsin School of Medicine, Madison
Election of 1978 Section Officers
- 12 Noon ISMA Board of Trustees Meeting (Luncheon)—Celebration B (second floor)
- 12 Noon Editorial Board Luncheon—Board Room (second floor)
- 3:00 p.m. House of Delegates Meeting—Regency C & D (second floor)
- 5:00 p.m. AMERICAN ASSOCIATION OF PHYSICIANS AND SURGEONS—Regency A & B (second floor)
Buffet
Panel—UPDATE MEDICAL MALPRACTICE LEGISLATION
Participants—Kent Masterson Brown, Attorney at Law, Lexington, Kentucky
James J. Stewart, Legal Counsel, ISMA, Indianapolis
David O'Malia, Deputy Attorney General, Indianapolis
- 7:30 p.m. Reference Committee Meetings
Reference Committee No. 1—Celebration A (second floor)
Reference Committee No. 2—Celebration B (second floor)
Reference Committee No. 3—Yellowstone (second floor)
Reference Committee No. 4—Yosemite & Everglades (second floor)
Reference Committee No. 5—Sequoia (second floor)

Monday, Oct. 24, 1977

- 7:30 a. m. Board of Trustees Breakfast—Celebration B
- 9:00 a.m. Registration Continues
Opening of Scientific Exhibits
- 11:00 a.m. to 2:00 p.m. Golf Tournament, Crooked Stick Golf Club, 1964 Burning Tree Lane, Carmel. (Listed in Golf Digest as one of the 100 greatest golf courses in U. S.)
Dr. Paul F. Muller and Mrs. Charles Van Tassel, co-chairmen.

SPEAKERS

CALVIN M. KUNIN, M.D.
Madison, Wis.

Professor and associate chairman, Department of Medicine, University of Wisconsin School of Medicine, Madison, and chief of medical service, Middleton Memorial Veterans Hospital, Madison; M.D. degree from Cornell University, 1953.



- 2:30 p.m. to 6:00 p.m. Tennis Tournament (men's and women's singles) Carmel Racquet Club, 225 East Carmel Drive, Carmel
Dean & Mary Grove, co-chairmen.
- 6:00 p.m. Cocktails (for golfers and tennis players) Crooked Stick Golf Club
- 7:30 p.m. Dinner (for golfers and tennis players) (Gourmet Chef) Crooked Stick Golf Club

GENERAL MEETING

(Possible Hours of Accreditation 2.0)

Victor H. Muller, M.D., Chairman, Commission on Convention Arrangements, Presiding
Regency C and D (second floor)

- 12 Noon to 3:00 p.m. Luncheon
WHITE CELL FUNCTION IN HEALTH AND DISEASE, Gerald L. Mandell, M.D., University of Virginia School of Medicine, Charlottesville
HOST DEFENSE MECHANISMS, Lowell S. Young, M.D., University of California, Los Angeles

GERALD L. MANDELL, M.D.
Charlottesville, Va.

Professor of Medicine and head of the Division of Infectious Diseases, University of Virginia; consultant, Walter Reed Army Medical Center; member, Phi Beta Kappa, Alpha Omega Alpha, F.A.C.P., American Society Clinical Investigators, Infectious Disease Society; M.D. degree from Cornell University.



Monday, Oct. 24, 1977

SPEAKERS

MEET THE PROFESSOR

3:00 p.m. (The Department of Medicine of Indiana
to University School of Medicine has ar-
5:00 p.m. ranged to conduct these Conferences.
Richard C. Powell, M.D., Chairman.)

*Possible Hours of Accreditation 2.0 for
entire Session)*

**THE NEWER ANTIBIOTICS AND
COMBINATIONS**, Arthur White, M.D.,
Professor of Medicine — Yellowstone
(second floor)

**TRAVELERS DIARRHEA AND OTH-
ER GASTROINTESTINAL INFEC-
TIONS**, James R. Meadows, M.D., Pro-
fessor of Medicine—Everglades (second
floor)

**IMMUNIZATIONS 1977-78—INFLU-
ENZA? MEASLES?** Martin Kleiman,
M.D., Assistant Professor of Pediatrics—
Yosemite (second floor)

**HOSPITAL-ACQUIRED INFEC-
TIONS**, Richard Kohler, M.D., Assistant
Professor of Medicine—Sequoia (second
floor)

4:30 p.m. **IMPAC Board Meeting—Canyon Hall**
to (second floor)

6:00 p.m.

7:00 p.m. **Dinner—INDIANA MEDICAL POLIT-
ICAL ACTION COMMITTEE—Ball-**
room (second floor)

Speaker: Congressman Guy Vander Jagt
(R) Michigan Chairman, National Re-
publican Congressional Committee

7:00 p.m. **Council Meeting, Indiana Academy of
Ophthalmology and Otolaryngology—**
Board Room (second floor)

Tuesday, Oct. 25, 1977

7:30 p.m. **Board of Trustees Breakfast—Yosemite**
(second floor)

7:45 a.m. **Phi Beta Pi Breakfast—Grand Canyon**
to (second floor)

9:00 a.m.

9:00 a.m. **Registration Continues**
Opening of Scientific Exhibits

Section on Emergency Medicine

Regency D (second floor)

(Possible Hours of Accreditation 6.0)

9:00 a.m. **BASIC CPR COURSE (Four-hour**
to **American Heart Association approved**
4:00 p.m. **course)**

Moderator—Michael D. Bishop, M.D.,
Bloomington

Lunch On Your Own

Election of 1978 Section Officers

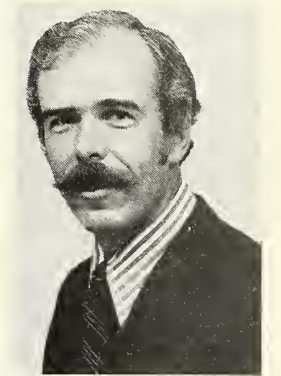
ARTHUR C. WHITE, M.D.
Indianapolis

Professor of Medicine and director,
Division of Infectious Diseases, I.U.
Medical Center; M.D. degree from
Harvard University.



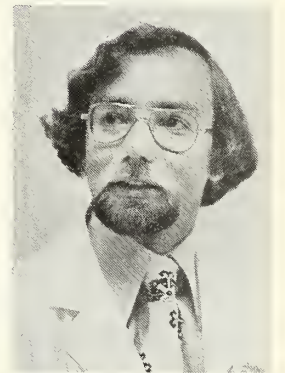
JAMES R. MEADOWS, M.D.
Indianapolis

Professor of Medicine, I.U. School of
Medicine, and consultant, I.U. Medical
Center hospitals; specialty in gastro-
enterology. M.D. degree from Indiana
University.



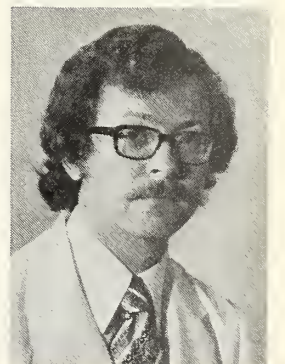
MARTIN B. KLEIMAN, M.D.
Indianapolis

Assistant Professor of Pediatrics, I.U.
Medical Center; specialty in pediatric
infectious diseases; M.D. degree from
State University of New York.



RICHARD B. KOHLER, M.D.
Indianapolis

Assistant professor, Department of In-
ternal Medicine, I.U. Medical Center;
specialty in infectious diseases; M.D.
degree from Temple University.



SPEAKERS



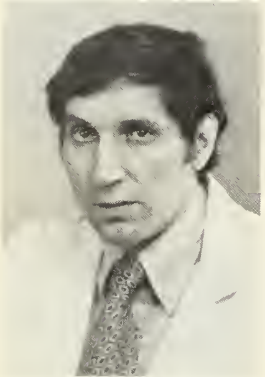
DANIEL J. AHEARN, M.D.
Indianapolis

In private practice and on staff of Methodist Hospital; specialty in internal medicine and nephrology; M.D. degree from New Jersey College of Medicine 1956.



ROBERT L. PARR, M.D.
Indianapolis

In private practice; specialty in pediatrics; M.D. degree from Indiana University, 1947.

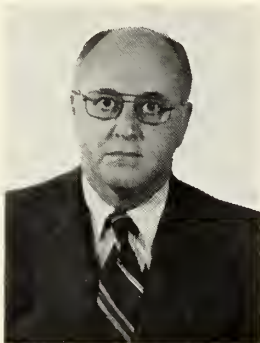


JOSEPH SILVA, JR., M.D.
Ann Arbor, Mich.

Associate Professor of Medicine, University of Michigan Medical School; specialty in internal medicine; formerly staff physician for infectious diseases, USAF Medical Center, Lockland Air Force Base, Texas; M.D. degree from Northwestern University, 1966.

WILLIAM DALE SAWYER, M.D.
Indianapolis

Professor and Chairman of Microbiology, I.U. School of Medicine; consultant to Scientific Advisory Board, Armed Forces Institute of Pathology, and site visitor, National Institute of Allergy and Infectious Disease; member Phi Beta Kappa, Fellow, American College of Physicians; M.D. degree from Washington University School of Medicine, St. Louis, 1954.



WILLIAM A. CRAIG, M.D.
Madison, Wis.

Associate professor of Medicine, University of Wisconsin, and clinical investigator, Madison Veterans Administration Hospital; specialty in internal medicine and infectious disease; M.D. degree from Tufts University, 1965.



Tuesday, Oct. 25, 1977

Section on Family Practice and Indiana Academy of Family Practice

Celebration B (second floor)

(Possible Hours of Accreditation 3.0)

IMMUNOLOGY UPDATE

- 9:00 a.m. INTERSTITIAL NEPHRITIS—WHAT IS IT? Daniel J. Ahearn, M.D., Indianapolis
- 10:30 a.m. Coffee break
Robert L. Parr, M.D., Indianapolis
Martin Kleiman, M.D., Indianapolis
- 12 Noon Luncheon
Election of 1978 Section Officers

American College of Physicians, Indiana Regional Meeting in association with Indiana Society of Internal Medicine and ISMA Section on Internal Medicine

Regency C (second floor)

(A portion of the scientific program is supported by a grant from ROERIG, DIVISION OF PFIZER PHARMACEUTICALS)

(Possible Hours of Accreditation 5.0)

Morning Session

Moderator—Douglas H. White, Jr., M.D., Indianapolis, President, Indiana Society of Internal Medicine

- 9:00 a.m. Welcome
- 9:05 a.m. Business Session
- 9:30 a.m. ANTIBIOTIC ASSOCIATED COLITIS, Joseph Silva, Jr., M.D., University of Michigan Medical Center, Ann Arbor
- 10:45 a.m. Break
- 11:00 a.m. PROSPECTS AND PROBLEMS IN RECOMBINANT DNA RESEARCH, William D. Sawyer, M.D., F.A.C.P., Indiana University School of Medicine
- 12:15 p.m. Buffet Lunch—Regency D (second floor)

Afternoon Session

Moderator — George T. Lukemeyer, M.D., F.A.C.P. ACP Governor for Indiana, Indianapolis

- 1:15 p.m. Annual Business Meeting
Election of 1978 Section Officers
- 1:30 p.m. Richard Allyn, M.D., F.A.C.P., Springfield, Illinois
- 2:00 p.m. RATIONAL APPROACH FOR MONITORING AND USAGE OF ANTIBIOTICS, William A. Craig, M.D., Veterans Administration Hospital, Madison, Wisconsin

Tuesday, Oct. 25, 1977

SPEAKERS

- 3:15 p.m. Break
 3:30 p.m. LAETRILE, THE LAW AND THE PRACTICING PHYSICIAN, William M. Dugan, M.D., F.A.C.P., Methodist Hospital, Indianapolis
 4:45 p.m. Adjourn

Section on Ophthalmology and Otolaryngology and Indiana Academy of Ophthalmology and Otolaryngology

Well House (third floor)

(Possible Hours of Accreditation 1.75)

- 9:00 a.m. General Discussion — DIVISION OF THE ACADEMY—PRO and CON
 to
 10:00 a.m.
 10:00 a.m. GOVERNMENT CONTROLS AND REGULATION RELATING TO OPHTHALMOLOGY and OTOLARYNGOLOGY, Harry W. McCurdy, M.D., Washington, D. C., Executive Director, American Council of Otolaryngology
 to
 11:45 a.m.
 11:45 a.m. NEW BLUE SHIELD PLAN FOR HEARING AND VISION DISORDERS,
 to
 12:15 p.m.
 Election of 1978 Section Officers
 Adjourn

ISMA Section on Public Health and Preventive Medicine and Indiana Association of Public Health Physicians, Inc.

Yosemite & Sequoia (second floor)

(Possible Hours of Accreditation 4.0)

Ivan T. Lindgren, M.D., President, Indiana Association of Public Health Physicians, Inc., Presiding

Infectious Disease and the Current Status of Immunization

- 10:30 a.m. THE STATUS OF MEASLES AND OTHER IMMUNIZATION IN INDIANA, Charles E. Barrett, M.D., Director Division of Communicable Disease Control, Indiana State Board of Health
 11:00 a.m. NATIONAL IMMUNIZATION PLANS, Alan R. Hinman, M.D., M.P.H., Director, Immunization Bureau of State Services, Center for Disease Control, Atlanta
 12:30 p.m. Luncheon
 Business Meeting
 Election of 1978 Section Officers
 1:30 p.m. NEW DEVELOPMENTS IN MANAGEMENT OF VIRAL HEPATITIS, Arthur White, M.D., Professor of Medicine and Director in the Division of Infectious Diseases, Indiana University School of Medicine

WILLIAM M. DUGAN, JR., M.D.
 Indianapolis

In private practice since 1969; assistant clinical professor of medicine, I.U. School of Medicine; staff, hematology clinics, Marion County General Hospital and Methodist Hospital; member, Tumor Board, Methodist Hospital; diplomate, American Board of Internal Medicine and Oncology; Fellow, American College of Physicians; M.D. degree from Indiana University in 1963.



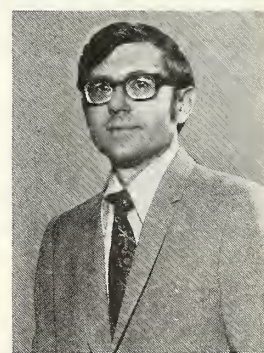
HARRY W. MCCURDY, M.D.
 Washington, D.C.

Executive Director, The American Council of Otolaryngology; Consultant to the Army Surgeon General—Otolaryngology; AMA Interspecialty Council—Otolaryngology Representative; M.D. degree from University of Pennsylvania, 1943.



CHARLES E. BARRETT, M.D.
 Indianapolis

Director of Communicable Disease Control Division, Indiana State Board of Health; specialty in communicable disease epidemiology; M.D. degree from Indiana University, 1966.



A financial contribution has been received from Bristol Laboratories, CIBA Pharmaceutical Company, Immke Circle Leasing, Inc., Eli Lilly and Company, Mead Johnson Laboratories, The Medical Protective Company, Merck Sharp & Dohme, Parke, Davis & Company, Professional Management, A. H. Robins Company, Schering Corporation, E. R. Squibb & Sons, Inc., and The Upjohn Company.

SPEAKERS



JAY L. GROSFELD, M.D.
Indianapolis

Professor and director, Section of Pediatric Surgery, I.U. School of Medicine, and surgeon-in-chief, James Whitcomb Riley Hospital for Children; M.D. degree from New York University School of Medicine, 1961.



RONALD FILO, M.D.
Indianapolis

Assistant Professor of Surgery and director of the Transplantation Service, I.U. Medical Center.



JOHN E. JESSEPH, M.D.
Indianapolis

Professor and Chairman, Department of Surgery, I.U. School of Medicine.



STANLEY J. DUDRICK, M.D.
Houston, Texas

Professor and Chairman, Department of Surgery, University of Texas Medical School, Houston.

Tuesday, Oct. 25, 1977

ISMA Section on Surgery, Indiana Chapter, American College of Surgery and Indiana Chapter, International College of Surgeons

Bryce Canyon (second floor)

(Possible Hours of Accreditation 2.0)

- 9:30 a.m. Business Meeting — Jay L. Grosfeld, M.D., Section Chairman, presiding
Announcements
Election of 1978 Section Officers
- 10:00 a.m. Scientific Program
Moderator: Jay L. Grosfeld, M.D.
INFECTION IN THE IMMUNOSUPPRESSED PATIENT, Ronald Filo, M.D., Assistant Professor of Surgery, Director, Transplantation Service, Indiana University Medical Center
- 10:25 a.m. Questions and Answers
- 10:30 a.m. **MANAGEMENT OF DIVERTICULITIS WITH PERFORATION; CURRENT CONCEPTS**, John E. Jessep, Professor and Chairman, Department of Surgery, Indiana University Medical Center
- 10:55 a.m. Questions and Answers
- 11:00 a.m. **Visiting Professor Oration**
THE IMPACT OF TOTAL PARENTERAL NUTRITION ON SURVIVAL IN PATIENTS WITH BURNS, FISTULAE, AND IMMUNOSUPPRESSION, Stanley J. Dudrick, M.D., Professor and Chairman, Department of Surgery, University of Texas Medical School, Houston
- 11:50 a.m. Questions and Answers
- 12:00 Noon **ADJOURN**
- 12:00 Noon Past Presidents' Luncheon—Yellowstone & Everglades (second floor)

Indiana Urological Association and ISMA Section on Urology

Grand Canyon (second floor)

(Possible Hours of Accreditation 3.5)

- 12:00 Noon Lunch
to
Election of 1978 Section Officers
- 1:00 p.m.

Tuesday, Oct. 25, 1977

SPEAKERS

1:00 p.m. STONE DISEASE, Norman Bell, M.D.,
to
1:30 p.m. Medical Department, Veterans Hospital,
Indianapolis

1:30 p.m. Questions
to
1:45 p.m.

1:45 p.m. DIAGNOSIS AND MEDICAL MAN-
to
2:00 p.m. AGEMENT OF URIC ACID STONES,
Speaker—Member of Urological Associ-
ates, Evansville, Indiana

2:00 p.m. DIAGNOSIS AND MEDICAL MAN-
to
2:15 p.m. AGEMENT OF CALCIUM OXYLATE
STONES, Michael H. Thomas, M.D.,
Elkhart

2:15 p.m. DIAGNOSIS AND MEDICAL MAN-
to
2:30 p.m. AGEMENT OF "STONES OF INFEC-
TION", Larry Gott, M.D., Indianapolis,
Indiana University Medical Center

2:30 p.m. Panel Discussion—WHAT IS AN ADE-
to
3:00 p.m. QUATE STONE WORKUP

3:00 p.m. Break
to
3:15 p.m.

3:15 p.m. CASE PRESENTATIONS OF UNUSU-
to
4:30 p.m. AL STONE PROBLEMS

1:00 p.m. Small County Delegates Meeting—Cele-
bration B (second floor)

5:30 p.m. Reception for Fifty Year Club—National
Parks Suite (second floor)

7:00 p.m. President's Reception—Regency Prome-
nade (second floor)

7:45 p.m. President's Dinner—Regency Ballroom
(second floor)

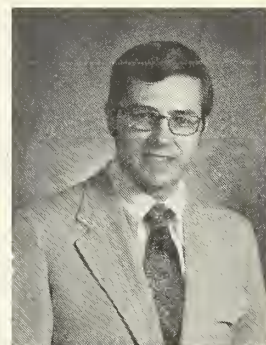
Wednesday, Oct. 26, 1977

7:30 a.m. Board of Trustees Breakfast—Yosemite
& Sequoia (second floor)

9:00 a.m. Final Meeting of the House of Delegates
Regency C & D (second floor)

MICHAEL H. THOMAS, M.D.
Indianapolis

Clinical Associate Professor, Depart-
ment of Urology, I.U. School of Medi-
cine; specialty in urology; member,
American Urology Association; Fellow,
American College of Surgeons; M.D.
degree from Indiana University.



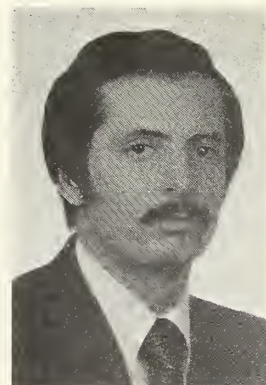
NORMAN H. BELL, M.D.
Indianapolis

Professor of Medicine and Pharma-
calogy and director of Clinical Re-
search Center, I.U. School of Medicine;
specialty in internal medicine and en-
doctrinalogy; member Alpha Omega
Alpha, American Society of Clinical
Investigation; M.D. degree from Duke
University, 1955.



LAWRENCE J. GOTT, M.D.
Indianapolis

Assistant Professor, Department of
Urology, I.U. School of Medicine and
chief of urologic surgery, Wishard Me-
morial Hospital; specialty in urologic
surgery; M.D. degree from University
of Illinois Medical School, Chicago.



Program—ISMA Auxiliary

President—Mrs. John R. Stanley, Muncie
 General Chairman of Women's Activities—Mrs. Herbert L. Sedam, Indianapolis
 Committee Chairmen—
 Luncheon—Mrs. Richard E. Wurster, Indianapolis
 Tea—Mrs. Stanley M. Chernish, Indianapolis
 Treasurer—Mrs. John W. Beeler, Indianapolis
 Registration—Mrs. Abner Bennett, Evansville
 Mrs. Willis W. Stogsdill, Indianapolis
 Mrs. Edward H. Daley
 Publicity—Mrs. Charles R. Alvey, Muncie
 Mrs. William M. Matthews, Indianapolis
 Golf—Mrs. Charles J. Van Tassel, Jr., Indianapolis
 Tennis—Mrs. Dean A. Grove, Carmel

Monday, Oct. 24, 1977

9:00 a.m. Registration
 Opening of Scientific Exhibits
 10:00 a.m. Tour of Medical Museum
 11:00 a.m. Golf Tournament, Crooked Stick Golf Club, 1964 Burning Tree Lane, Carmel
 to
 2:00 p.m.
 2:30 p.m. Tennis Tournament (men's and women's singles) Carmel Racquet Club, 225 East Carmel Drive, Carmel
 6:00 p.m.
 6:00 p.m. Cocktails (for golfers and tennis players) Crooked Stick Golf Club
 7:30 p.m. Dinner (for golfers and tennis players) (Gourmet Chef) Crooked Stick Golf Club
 2:00 p.m. Tea—Governor and Mrs. Bowen's Residence—4750 N. Meridian Street, Indianapolis (Buses available at hotel—courtesy of Eli Lilly and Company)
 to
 4:00 p.m.
 7:00 p.m. Dinner—INDIANA MEDICAL POLITICAL ACTION COMMITTEE
 Speaker—Congressman Guy Vander Jagt (R) Michigan, Chairman, National Republican Congressional Committee

Tuesday, Oct. 25, 1977

9:00 a.m. Registration Continues
 Open Board Meeting (All physicians' spouses welcome), Regency A (second floor)
 10:30 a.m. Workshop—Rape and Personal Safety, Sgt. Jean Bray, Indianapolis Police Dept.
 12:15 p.m. Fiftieth Anniversary Luncheon, Harrison Room (third floor)
 Speaker: Mrs. Rose Gardner, Louisville, First Vice President, American Medical Association Auxiliary
 5:30 p.m. Reception for Fifty Year Club—National Parks Suite (second floor)
 7:00 p.m. President's Reception—Regency Promenade (second floor)
 7:45 p.m. President's Dinner—Regency Ballroom (second floor)

Wednesday, Oct. 26, 1977

Free Time

Our Fiftieth Anniversary—Plan to Come and Help Us Celebrate

Reports of Officers

Executive Director

In making this second report to the House of Delegates and members of ISMA, I am pleased to relate that the financial condition of the Association continues healthy, as reflected in recent operating statements. This is partly because membership is at a level above budgeted projections while expenses have remained below budget. A detailed financial report will be presented by the Treasurer at the ISMA annual meeting. During the annual audit conducted by George S. Olive Company last October we requested they present us with a management letter setting forth recommendations for strengthening internal financial and management controls. Practically all the recommendations contained in this management letter have been implemented.

Reflecting further on the important events of the past year, I think it appropriate to report to you some of the administrative changes and actions that have taken place. ISMA has hired a full-time legislative analyst. This individual is a young attorney who represents ISMA in the state legislature, in addition to our two professional lobbyists. His other duties include handling corporate matters, formulating testimony on both state and national legislation, coordinating ISMA's new countersuit program and providing legal advice to members where appropriate.

A third fieldman is being phased into the operation in order to bolster efforts and more adequately exercise surveillance of the HSAs. Accordingly, territorial responsibilities are being revamped to coincide as closely as possible with the three Health Services Areas.

With the concurrence and support of the Board of Trustees, IMPAC has recently employed the services of a full-time staff man whose principal function will be to stimulate physician involvement in the political process through political education. At the outset, priority will be given to membership development and it is thought that increased membership will more than offset the added cost of his services. Reporting and record-keeping have become burdensome under the new FEC regulations and this is an area which merits staff support.

Revised personnel policies, approved by the Executive Committee, were distributed to all employees. Job descriptions for the entire staff are still in the process of development, due to continuing realignment of functions.

Progress has been made toward im-

proved communications through: (1) A special Information Bulletin for the Board of Trustees and leadership, distributed periodically. (2) Publishing the *News Flash* on a more regular basis. (3) Distributing a Summary of Board of Trustees actions to the entire membership following each Board meeting. (4) The establishment of an information clearinghouse at ISMA headquarters to facilitate the participation of physicians serving on HSA Boards and Subarea Advisory Councils in the three Health Services Areas. In addition Legislative and PAC newsletters are being planned by staff.

Unfortunately, the Tel-Med program was discontinued in June due to lack of funds with no prospect of additional funding from outside sources. ISMA will continue to maintain the franchise and offer interested county medical societies the opportunity to utilize the equipment and program in their respective locales. Blue Cross-Blue Shield has expressed interest in co-sponsoring the program with ISMA and is currently assessing costs.

The Future Planning Committee can boast of two major achievements over the past year—completion of a feasibility study on computer applications and the conduct of a membership opinion poll, the results of which have been reported to the Board of Trustees and appropriate action taken.

After a thorough study of the health insurance marketplace, the Board of Trustees decided to retain Blue Cross-Blue Shield as the carrier for the ISMA-sponsored members' health insurance program. An improved benefit structure was negotiated and descriptive literature will be mailed to all those enrolled. The Blues have also assigned a knowledgeable person to the ISMA program to handle all inquiries and expedite complaints.

At its July meeting the Board of Trustees will be exposed to the AMA-structured basic seminar on negotiations. Increasing third party intrusion into the practice of medicine makes it imperative that organized medicine be prepared to send skilled representatives to the bargaining table with its demands.

Discussions are underway with the Medical Licensing Board to provide them with required computer services which, hopefully, will avoid future problems associated with the periodic registration of licenses.

A concerted effort has been made this year to provide testimony and comments on proposed national legislation and regulations as a supplement to AMA's activities. It is no secret that Indiana's congressional delegation is much more receptive to receiving comments on key health issues from voting constituents than from sources outside of Indiana. Moreover, federal regulations and legislation possess the potential for exerting

greater influence on the practice of medicine than that which is generated at the state level.

Although the next session of the General Assembly is scheduled to be a short session, I am sure it will not be short on legislative challenges. The chiropractors will undoubtedly again be seeking their own separate licensing board and an expanded medical role. A certificate of need bill will almost certainly be introduced, which may or may not include physicians' offices, and will probably depend upon our ability to influence the development of such legislation. We should anticipate a movement by the optometrists to seek approval to use drugs for therapeutic and diagnostic purposes, thereby expanding their scope of practice. Similar legislation exists in West Virginia and North Carolina.

The Medical Licensing Board has propounded rules and regulations to implement the new Medical Practice Act. Included in these new rules and regulations is a continuing medical education requirement tied into the re-registration of licenses. The Board intends the requirement to be voluntary at the outset but to eventually become mandatory. Public opinion, or, more precisely, what legislators think is public opinion, looms as an important consideration for ISMA in any discussion of mandatory CME.

Consistent with his inaugural promise, ISMA President John W. Beeler has appointed a Committee on the Impaired Physician. The chief purpose of the committee is to devise guidelines and methods for identifying physicians with various disabilities and persuading them to seek help. The committee intends to serve as an intermediary between the functioning impaired physician and the Medical Licensing Board. In order to facilitate this relationship, a member of the Medical Licensing Board has been appointed to serve on the committee. The committee has met several times and is making significant progress.

The Board of Trustees has approved the holding of a major conference on Rising Health Care Costs. Such a conference would include leaders from organized medicine, labor, industry, insurance, hospitals, etc. The principal focus of the conference will be on identifying effective private sector mechanisms for dealing with rising health care costs. The project has been referred to the ISMA Public Relations Commission for implementation.

Today, most trade associations are prospering as never before. The forward-looking associations are providing interpretation and facts, moving out ahead on issues, anticipating problems and trends. A heavy emphasis is being placed on the intelligence function in-depth analyses, providing government with hardheaded, credible information for its decisions and at the same time feeding

back information to decision-makers. The trade associations that are growing fast are dynamic and aggressive, feistier and out front—digging into technical matters with competent staffs. This is the image I want for ISMA.

Lobbying is changing in line with the new type congressman. The effective lobbyists are those with know-how—those who make sense because they offer expertise in their industry and have credibility. Good ole boy lobbyists who relay on cronyism are becoming anachronisms. This is one reason for Big Labor's lack of success with the present Congress, since some of the unions are still lobbying in the old way.

The importance of wider personal involvement at all levels—county, state, specialty society and national—cannot be over-emphasized. Imagine how much stronger organized medicine could be if only each current member brought just one colleague, who does not now belong.

Members should look on their association as an investment—of time and money—use its services, facts and data, technical assistance, government relations, etc. If you have not been satisfied with results thus far, why not get involved and work from within for necessary changes. You have a lot at stake.

DONALD F. FOY
Executive Director

Treasurer

A detailed report of the financial condition of the association at September 30, 1977, will be made available to the reference committee prior to the annual meeting.

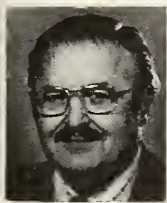
As was done last year, I am presenting an unaudited report of the financial condition as of May 31, 1977, and the figures from the Sept. 30, 1976, audit, for comparison. I hope in this way it will give our members a more current review of the financial condition of the State Association. At May 31 expenses overall are well within budget.

ARVINE G. POPPLEWELL, M.D.
Treasurer

INDIANA STATE MEDICAL ASSOCIATION
Statement of Financial Condition

ASSETS			LIABILITIES AND FUND BALANCES		
	5/31/77	9/30/76			
GENERAL FUND:			GENERAL FUND:		
Cash on deposit	\$ 125,815	\$ 75,866	Accounts payable	\$ 3,714	\$ 11,933
Investments—at cost:			Accrued taxes	—	473
U.S. Treasury Bonds—long term	35,083	35,083	Dues payable to AMERF	20,825	21,230
U.S. Treasury Bills, Certificates of Deposit—short term	924,622	558,451	Dues payable Counties, Districts, AMA	44,077	—
Accounts receivable	39,699	28,740	Unearned portion of current year dues	422,046	186,150
Prepaid expense and miscellaneous assets	8,995	20,118	Deferred annual meeting income	—	2,825
Office furniture and equipment—net of accumulated depreciation	20,509	20,812	Deferred contributions—Tel Med	1,186	3,864
	1,154,723	739,070	Lease contract payable	477	723
			Fund balance	662,398	511,872
				1,154,723	739,070
BUILDING FUND:			BUILDING FUND:		
Cash on deposit	2,311	3,822	Accrued taxes on rental properties	1,043	1,121
Cash in savings account	8,355	8,140	Damage deposits and accounts payable	743	686
U.S. Treasury Bills	273,412	255,744	Loans from members (non-interest bearing)	19,375	19,475
Prepaid and deferred expenses	2,055	604	Fund balance	629,486	619,645
Headquarters property:				650,647	640,927
Land	69,188	69,188			
Office building and improvements—net of accumulated depreciation	219,753	225,930			
Rental properties—net of accumulated depreciation	75,573	77,499			
	650,647	640,927			
STUDENT LOAN FUND:			STUDENT LOAN FUND:		
Cash in savings account	19,190	19,190	Fund balance—principal balance appropriated from General Fund	40,000	40,000
Certificates of deposit	20,810	20,810		40,000	40,000
	40,000	40,000			
MEDICAL DEFENSE FUND:			MEDICAL DEFENSE FUND:		
Cash in savings account	44,160	38,518	Fund balance	69,460	63,818
U.S. Treasury Bonds	25,300	25,300		69,460	63,818
	69,460	63,818		\$1,914,830	\$1,483,815
	\$1,914,830	\$1,483,815			

First Trustee District



BERNARD B. ROSENBLATT, M.D.
Trustee

The First District Medical Society held its annual meeting on May 19 at the Evansville Country Club. The winners of the second Bob Acre Memorial Golf Tournament were Dr. John Tisserand, who won Low Gross in an exciting playoff with Dr. Bill Ritchie, and Dr. Dennis Hodge, a resident physician at St. Mary's Hospital, Low Net.

A report to the membership from ISMA called attention to the Public Relations Commission's plans for a conference on health care costs and to employment of Mr. Rick King as legislative analyst, and an employee for IMPAC. Information was also supplied on the current status of medical liability insurance in Indiana and on a feasibility study of in-house computer capability for the Association.

Dr. Ralph Carlson, First District Trustee to the Indiana Blue Shield Board of Trustees, reported that Indiana Blue Shield is considering entering the dental insurance business. Dr. Carlson also noted that the Federal Trade Commission has subpoenaed information from Blue Shield, and a law firm has been retained to deal with the FTC.

Dr. Gilbert Wilhelmus reported for AMA in the absence of Dr. Corcoran and called attention to the fact that Dr. Corcoran is running for re-election to the AMA Council on Medical Education at the annual AMA meeting in June. Dr. Wilhelmus also reported that he had been named by ISMA, along with Don Foy, to become educated in the art of negotiations and that he would be attending an advanced seminar soon.

In the election of officers, Dr. James Marvel was elected First District president for the coming year, with Dr. Forrest Radcliff chosen vice-president and Dr. Frank Hilton secretary-treasurer. Dr. John Bizal was elected trustee to the Indiana State Medical Association.

As retiring Trustee, I was most gratified when a resolution was presented to the District which had previously been adopted by members of the Vanderburgh County Medical Society, and which recognized my years of service as ISMA trustee and alternate trustee from the First District. It has been both a privilege and a pleasure to serve my colleagues in this fashion, and I am indebted to them for choosing me to represent them.

BERNARD B. ROSENBLATT, M.D.
Trustee

Second Trustee District



PAUL W. HOLTZMAN, M.D.
Trustee

It has been my distinct privilege to serve yet another year on the Board of Trustees.

Orchids to the staff and those officers of the Association who are diligently and thanklessly working for the benefit of ISMA. Orchids also to those members who are slowly realizing the value of ISMA and AMA.

Onions to those who are still unaware of the fact that they have in their grasp, *the greatest union on earth.*

PAUL W. HOLTZMAN, M.D.
Trustee

Third Trustee District



THOMAS A. NEATHAMER, M.D.
Trustee

This past year our main concerns have been with the malpractice law, National Health Insurance, PSRO and Blue Cross and Blue Shield. I am very sorry that I cannot report that we have made very much progress in any of these areas. National Health Insurance still appears to be on the horizon for the practicing physician.

Indiana stands particularly alone in opposing any type of National Health Insurance. At the last delegates' meeting, due to the decision of the Board of Trustees, our delegates definitely testified against any form of National Health Insurance. The malpractice law so far has been working quite well. There is now a test case in process to determine its constitutionality; however, this case has not gone far enough to have any definite decisions made on the law.

PSRO is still in progress throughout the state; however, it has been progressing much slower than the Federal Government had anticipated and some of the PSRO members in Indiana, I am sure, would like for it to progress faster. However, there is still no functioning PSRO in our district. Blue Cross and Blue Shield have caused some problems throughout the year; however, the Board of Trustees has kept open lines of communications and several minor problems

between Blue Cross and Blue Shield and the physicians have, I think, been resolved satisfactorily. I hope that next year's report will be somewhat more optimistic than this year's. I have attended most of the Trustee meetings and will continue to do so, keeping the district's views in mind whenever we have an issue to vote on.

THOMAS A. NEATHAMER, M.D.
Trustee

Fourth Trustee District



HOWARD C. JACKSON, M.D.
Trustee

The Fourth District Medical Society met at the Dearborn Country Club on May 5, 1977. The men played golf and the ladies visited the race track in Cincinnati. Dr. Brockton L. Weisenberger of Columbus presented an interesting scientific talk on "Occupational Medicine." Mr. Ray Richardson of Martinsville presented the evening program, which was well attended and well received.

At the business meeting Dr. Howard Jackson of Madison was elected trustee for another three year term. Dr. Larry Williams of Madison was elected president of the Fourth District Medical Society; Dr. Broockton Weisenberger was elected vice-president and Dr. Ott McAttee of Madison was elected secretary-treasurer. The 1978 district meeting will be held on May 24 at Madison.

Dr. John Beeler, president of ISMA, Dr. Eli Goodman, chairman of the Board of Trustees, and Mr. Donald F. Foy, executive director, were guests of the Fourth District Medical Society at our meeting.

As your trustee, I have visited some of the county society meetings but, unfortunately, not all. I have sent out reports after each Board meeting and also on other important occasions. Of course, we have been preoccupied with government interference into the private practice of medicine, as manifested by PSRO and HSAs in the past year. Now we must turn our attention to continuing medical education, what with many legislatures and state medical associations looking at requiring a yearly quota of continuing medical education for relicensure and membership, respectively. I am at the present polling the members of the Fourth District Medical Society as to their views regarding this issue.

HOWARD C. JACKSON, M.D.
Trustee

Fifth Trustee District



CLEON M. SCHAUWECKER, M.D.
Trustee

Although I have not searched the Archives, I believe I can safely say that the Fifth District can report a "first" since its inception. Ground was broken for two NEW hospitals this spring. Being from Greencastle, and nearing the end of my second term as trustee, I shall report on Putnam County first. Ground was broken this spring for a new hospital to replace the present structure. It will be located approximately three miles south of Greencastle on State Road 231. As to the time of completion, many dates have been given, and later "un-given." The safest bet is "in the vicinity of two years."

The new hospital at Terre Haute had groundbreaking ceremonies in June for the Terre Haute Regional Hospital. Actual construction is slated for August. It is to replace the former St. Anthony's Hospital and will be located on the south side of Terre Haute. Union Hospital at Terre Haute was also extensively remodeled with a new labor and delivery suite, a new intensive pediatric care unit and new intensive care unit for adults.

The Fifth District held its annual meeting at the Holiday Inn south of Greencastle on May 18. Attendance was good. Among the guests were Dr. John Beeler, Dr. Eli Goodman, Dr. Malcolm Scamahorn, Mr. Don Foy and Mr. Bob Amick. During the business meeting, an informal vote was taken as to the members' attitudes concerning "compulsory" relicensure. The vote was almost unanimous in opposition. However, the feeling was almost unanimous in favor of "voluntarily" stressing the importance of and the necessity for continuing medical education.

The speaker, Dr. Daniel S. Giroux of the Argonne Laboratories, was well received. He spoke on the atomic energy and other energy problems. It was presented in a delightful and entertaining manner and was quite humorous.

The officers elected for the coming year are: President: Dr. Frank Swaim, Rockville; vice president: Dr. Richard Bloomer, Rockville; secretary-treasurer: Dr. Clyde Jett, Terre Haute.

The tentative plans are for the 1978 meeting to be held at the Terre Haute Country Club on May 3.

CLEON M. SCHAUWECKER, M.D.
Trustee

Sixth Trustee District



GLEN WARD LEE, M.D.
Trustee

The Sixth District Annual Meeting was held at the Greenfield Country Club on May 11, 1977. Mr. Richard R. King, legislative analyst for ISMA, gave a report on current status of "State and National Legislation." Mr. Donald F. Foy, executive director for ISMA, gave an update of the activities of the association, and Dr. John Beeler, president, gave a report on his activities and questions he is encountering in representing the State Association. Also, Mr. Herb Dixon, from Blue Shield, reported on the changes in our Comprehensive and Major Medical Insurance, and asked for reports of any problems. Dr. James Harshman, Kokomo, chairman of the Board of Trustees, gave a report of the activities of the board. Time and effort of all of the above to participate in our meeting were greatly appreciated.

Mr. Robert Amick, of our field staff, promised that a visitation to each of the County Societies in the Sixth District will be made in the next year and Dr. Glen Ward Lee, trustee of the Sixth District, will accompany him on these visits when possible. The meeting was attended by 36 people and the presentations were made so that a round table discussion of the matters brought up could be had. This format permitted free discussion and was enjoyed by all the participants.

The business meeting was held at 4 p.m., presided over by Dr. C. G. Clarkson of Richmond, president of the Sixth District. Dr. O. L. Webb, New Castle, was elected our new president for 1978. Dr. Hal Rhyneanson, Fortville, was elected president-elect. Dr. C. V. Sage, Richmond, was nominated for the Blue Shield Board from the Sixth District. Dr. Glen Ward Lee, Sixth District trustee, asked for reports of any problems arising in the County Societies of the district and pointed out any requests for change in membership status must be approved by the County Societies and submitted to Dr. Lee before it can be submitted to the ISMA Board of Trustees for consideration. A special form for this purpose will be furnished to any County Society secretary upon request.

Cocktails and dinner were by courtesy of the Sixth District Medical Society. Dr. Joseph A. FitzGerald, director, Outpatient Clinic at Larue Carter Hospital, entertained the audience with a

talk entitled "Adjusting To Being Single Again." Next year's meeting will be held in Shelbyville at a time to be decided later.

Subsequent to the meeting, Mrs. William R. Tindall, Shelbyville, was renominated from the Sixth Congressional District to the IMPAC Board.

GLEN WARD LEE, M.D.
Trustee

Seventh Trustee District



JOHN O. BUTLER, M.D.
Trustee



JOHN G. PANTZER, M.D.
Trustee

The Seventh District Medical Society is proud of its member, Dr. John W. Beeler, who is now completing a productive and successful year as president of the Indiana State Medical Association. We feel sure that all the districts will want to join the Seventh District in extending a hearty "thank you" to John for all his work in our behalf.

This year's meeting was held June 8 at the Valle Vista Golf Resort in Greencastle. Despite intermittent heavy rain, several members and wives managed to complete a full round of golf. The meeting also marked the inauguration of an annual tennis tournament for the Seventh District.

Dr. Charles R. Thomas, president, presided at the well attended business meeting. The first item of business was selection of Seventh District officers. Dr. Stephen L. Hardin of Morgan County was elected to succeed Dr. William Stafford as president elect. Dr. Malcolm Scamahorn was reelected secretary-treasurer.

Based on previous action by the District, one ISMA trustee and two alternate trustees were to be elected. Dr. Donald C. McCallum was elected unanimously to succeed Dr. John Butler as Seventh District trustee. Dr. I. E. Michael was elected to a two-year term as alternate trustee to succeed Dr. McCallum. Dr. Gerald Kurlander was elected to a two-year term as alternate trustee to succeed Dr. Paul Muller.

Dr. Muller, who for personal reasons decided not to seek reelection as alternate trustee, received thanks from many of

the members in attendance. We feel sure that all the District members will join us in this formal thank you for a job well done. Although, we have lost an able representative, we are pleased to know that we will still be able to turn to Paul for assistance in the future.

It is an apparent concern that future ISMA endeavors should focus on unification of physicians and seek to provide a broader base representation of members. An action in 1968 recognized disproportions of representation and as a result provided the Seventh District with better representation on the Board of Trustees but similar adjustments have not occurred regarding Commissions, Committees, or Reference Committees of the House of Delegates. To continue in this philosophy, the Seventh District has unanimously submitted a resolution to the ISMA House of Delegates which is designed to provide more proportional representation on ISMA Commissions.

The trustees have made an effort to attend the meetings of the County Societies in the District. We have enjoyed this opportunity to meet with our constituency and hope that similar interchange of ideas will take place in the year ahead.

We also feel it appropriate to note that our nominee to the Blue Shield Board of Directors, Dr. B. T. Maxam, has been doing a yeoman's task in that role. We have found Bev open to suggestions and genuinely interested in our concerns. Like your trustees, Bev has attempted to meet with a number of the Seventh District members in an effort to obtain the broadest base for his decisions. We thank Dr. Maxam for his continued efforts on the Blue Shield Board of Directors.

JOHN O. BUTLER, MD.
JOHN G. PANTZER, M.D.
Trustees

I would like to take this opportunity individually to extend thanks on behalf of the entire District to Dr. John Butler for his long and dedicated service to physicians of the Seventh District and Indiana. Since 1965, John served on the ISMA Board of Trustees, first as an alternate and then for two full terms as trustee. This past December John also completed a term as a member of the ISMA Delegation to the American Medical Association. He has served capacities too numerous to mention here. In all his roles, he continually endeavored to do the very best for his profession.

To John for all his work, and to Martha Butler, M.D., for her support and sharing: thank you.

JOHN G. PANTZER, M.D.

Ninth Trustee District



JOHN A. KNOTE, M.D.
Trustee

Initially, I wish to thank members of the Ninth District of the Indiana State Medical Association for affording me the privilege of representing this area on the ISMA board of trustees.

This report will include a summary of activities of the ISMA board of trustees since October, 1976 and some items for current and future consideration.

The trustees were actively involved (through the legislative committee of the board, in addition to representation on the Legislative Commission) with state legislation and with consideration of national legislation involving medicine.

We opposed the laetrile bill to no avail at the state level. Generic substitution of a prescribed drug did not receive a hearing in this session. Immunity (of physicians) in utilization review passed both houses. Definition of death passed the house, but did not receive a Senate hearing. The physicians' assistant bill passed both houses. A bill to strengthen the medical review panel selection process (for medical liability cases) passed both houses. Most significantly, the bill to separately license chiropractors was defeated, and the certificate of need bill was not passed. All of these bills were at the state level.

On the national level, we are currently very concerned about amendments to the Federal Trade Commission regulations which would give federal interests direct access to physicians' office records. In addition there is concern by the ISMA members at the medical center about a House of Representatives bill which would classify house staff members as employees rather than students. Of course, the overriding spectre of government interference remains the major concern of medical practitioners at this time.

Of national regulations which are affecting us locally at this time, the activities of HSAs and P.S.R.O.s will require our active surveillance and continued attempts to modify those forms of interference to the advantage of patients and physicians.

One additional factor of interest was the correct impression by many local practitioners that Criteria and Standards (and Guidelines) for Areawide Planning of Perinatal Services had been established without proper consideration of obstetrical needs in smaller hospitals out-

side metropolitan areas. Hopefully, the response of the Indiana State Medical Association Board of Trustees and Dr. Harshman (chairman of the Board) was sufficient to forestall regulations by the State Board of Health which might have hampered obstetrical service in smaller hospitals.

Finally, I have received several complaints about relationships between Blue Cross-Blue Shield and physicians and between that company and patients. The ISMA Board of Trustees is currently reviewing any complaints that doctors or patients may have regarding relationships with Blue Cross-Blue Shield. Please summarize any such comments and forward them to me in writing.

I hope to have personal contact with more of the district physicians at your county society meetings in the coming year. Please contact me if I can represent you more effectively at the state level.

The 1977 district meeting was held in Monticello with the White County Medical Society as host. Dr. Max N. Hoffman was reelected Alternate Trustee. The 1978 meeting, to be hosted by the Hamilton County Medical Society, will be held in Tippecanoe County.

JOHN A. KNOTE, M.D.
Trustee

Tenth Trustee District



MARTIN J. O'NEILL, M.D.
Trustee

The last meeting of the Tenth Trustee District was held Sept. 8, 1976, at the Woodmar Country Club, Hammond, with a record attendance of 175 members. The day started with a golf tournament, followed by a business meeting at 5 o'clock, then a cocktail hour and dinner. Mrs. Henry Giragos presented a fashion show at 4 o'clock for the ladies, with Auxiliary members as models. There were 40 ladies present.

Golf winners were: Low gross, Dr. E. J. DeGrazia, Valparaiso; low net, Dr. Michael Allegretti, Hammond; closest to the hole, Dr. Ramon Blanco, Dyer. Mrs. Thomas Wooden had low score for the ladies.

Dr. Joseph Siekierski, Tenth District president, conducted the business meeting, at which Dr. Martin J. O'Neill reported on the District activities for the past year. Dr. Vincent Santare, ISMA president, reported on activities at the state level and reminded members of the State Association meeting to be held in Indianapolis Oct. 9 to 12 and encouraged attendance. The minutes for the June

1975 and January 1976 meetings were approved. Dr. James Brown, Valparaiso, was elected Tenth District president and Dr. B. M. F. Palmer, Hammond, was elected secretary.

Dr. O'Neill presided at the dinner, which was attended by 160 physicians, wives and guests. He introduced Dr. John Budd, president-elect, AMA, Dr. Lowell H. Steen, trustee AMA, Dr. Vincent J. Santare, president ISMA, Dr. John W. Beeler, president-elect ISMA, Dr. Eli Goodman, chairman ISMA Board of Trustees, Dr. James Harshman, AMA delegate, Dr. Peter Petrich, AMA delegate; Dr. Thomas C. Tyrrell, alternate AMA delegate, Dr. Malcolm Scamhorn, AMA delegate, Dr. Leonard Neal, alternate Tenth District trustee and chairman of the board of Lake County Medical Society, Dr. Lambro Dimitroff, president, Lake County Medical Society, Dr. Joseph Siekierski, president, Tenth District, Dr. James F. Fitzpatrick and Dr. Peter Gutierrez, Indiana Blue Shield Board, Mr. Donald F. Foy, executive director, and Howard Grindstaff, field representative ISMA, and Mr. John Twyman, executive director of Lake County Medical Society. Present, but not introduced due to an oversight, were Dr. Lee Trachtenberg, president, Calumet Area Foundation for Medical Care, and Mr. Charles Shoemaker, the executive director of the Foundation.

Mr. Don Laser of Laser Pharmaceutical Company donated a television set that was given away as a door prize.

The speaker for the evening was Richard "Digger" Phelps, highly successful basketball coach at Notre Dame. He emphasized the necessity of improving the standards of elementary education in order for students to be properly prepared for high school and college and encouraged physicians and their wives to make their legislators aware of the deficiencies in primary education, in order that the necessary improvements be accomplished. Following his talk, he answered many questions pertaining to basketball, players and recruitment.

Lake County Medical Society officers elected during the year were Dr. Lambro Dimitroff, president, and Dr. David E. Ross, secretary. Porter County Medical Society installed Dr. Frank Sturdevant, president, and elected Dr. Charles Griffin, secretary, and Dr. James Brown, president-elect. Dr. Lee Trachtenberg was reelected president of Calumet Area Foundation for Medical Care and Mr. Charles Shoemaker continues as executive secretary.

As Trustee of the Tenth District, I am invited to attend the monthly meetings of the Lake County Medical Society to

discuss the activities of the Board of Trustees of ISMA. I miss very few meetings because I find them informative and helpful in making my decisions on questions that come up at ISMA Board sessions. I also attend the Porter County Medical Society meetings. A revision of the Constitution of Porter County Medical Society was made and approved by the society during the year.

The Calumet Area Foundation for Medical Care is now seven years old and continues to meet the challenge of medicine in the socioeconomic sector. The Coordinated Care Program (CCP) under the guidance of Dr. Forrest R. LaFollette has produced a worthwhile study of hospital utilization. At present, all Lake County hospitals, with two exceptions, are participating in the program and an agreement with Inland Steel has been renegotiated for another year. A marketing effort for new company clients has been initiated this year and there are at least two interested companies.

In the area of PSRO, the Foundation continues to be dealing with the Calumet Area Professional Review Organization (CAPRO) during its planning phase. Discussions are under way with the Federal Government to attain conditional status for the area. It is anticipated the PSRO will receive a conditional contract in July or August. Since CAPRO involves Area I—Lake, Porter and LaPorte counties—membership in CAPRO is not dependent upon membership in CAFMC.

I would like to mention that the Tenth District is proud to have in its membership immediate past president and member of the Executive Committee of ISMA, Dr. Vincent Santare; AMA trustee, vice-president of AMA-ERF, and commissioner to JCAH, Dr. Lowell Steen, and ISMA alternate delegate to AMA, Dr. Thomas Tyrrell.

MARTIN J. O'NEILL
Trustee

Eleventh Trustee District



JAMES A.
HARSHMAN, M.D.
Trustee

As each succeeding year passes, frustration grows concerning the intrusion of government into the private practice of medicine. Never a week passes but what one hears uttered "I'm quitting in a couple of years—I can't stand the bureaucratic paperwork any longer." In-

deed this attitude has penetrated to the younger physicians as well as the older ones.

It is increasingly evident that socialists, the federal government, and its agencies are determined to destroy the professions—medicine, dentistry and, to some extent, even the legal profession. Occasionally, two different governmental agencies are on opposite sides of an issue and we are caught in the middle. Recently a high Department of Health, Education, and Welfare administrator advised the Secretary, DHEW, that the supply of physicians should be "constrained" to decrease utilization of health services and subsequently reduce total expenditures. On the other hand, the Federal Trade Commission has charged that the American Medical Association has been in restraint of trade by limiting the supply of physicians through its accrediting of medical schools!

Without question, the "Third House" of government—the bureaucrats and full-time congressional staffs—are in firm control of our government. In addition, they are insulated from public view and scrutiny. Congress has abdicated much of government to this group. Mechanisms must be devised to expose these employees of the federal government and, more importantly, to make them accountable to the public. Too frequently, federal regulations are passed which are contrary to the intent of the original enabling legislation. The liberal attitudes of Congress added to the socialism of federal bureaucrats have accounted for the intrusion of government into our daily lives. This has accounted for the frustration so prevalent in the medical profession.

Never before has the challenge been greater for the leaders of the medical profession to find solutions to the problem of "How to handle the Third House." Our patience is wearing thin and time is running out. Never before has there been a greater need for a strong and unified voice for organized medicine.

Last September, Huntington County was host to the Eleventh District Medical Society in Huntington. The meeting was well attended. Dr. Jose Oller, president of the Council on Medical Staffs, was guest speaker for the evening. At the business meeting Dr. William Dannacher of Wabash was elected president and Dr. Fred Poehler of LaFontaine was reelected secretary. Wabash County will be the host for the next meeting, to be held at the Peru Mississinewa Country Club on Sept. 21, 1977.

JAMES A. HARSHMAN, M.D.
Trustee

Twelfth Trustee District



ALVIN J. HALEY, M.D.
Trustee

The Twelfth District ISMA meeting will be held Sept. 8, 1977, at the Imperial House Motel in Fort Wayne. The most important business will be the election of an alternate trustee.

Franklin A. Bryan, M.D., has pursued a successful incumbency, with a great attendance record, diligent pre- and post-meeting work, complete and competent meeting presentations. He has established a reputation of ability with affability. He is the ISMA expert on the medical practice act.

Dr. Bryan will be a candidate for reelection. I wish publicly to thank him for being an able consultant and an effective substitute.

At this moment, the "hot" item concerns compulsory continuing medical education, i.e., education necessary for relicensure or license re-registration. Despite a long participation and interest in CME and despite my current professional medical education practice, I disfavor compulsory CME. I oppose making CME a prerequisite for relicensure or re-registration for the following reasons:

1. Voluntary CME is adequate. The Indiana University School of Medicine is doing a great job with its CME programs and notes greatly increased attendance. The ISMA and its education commission likewise are leading the way in establishing and encouraging valid voluntary programs; so are specialty societies.
2. Presently, no convenient recording system is operational for CME hours.
3. No recording cycle is universally accepted.
4. No problems are solved by compulsory CME, such as the malpractice crisis, the disabled physician problem (alcohol, other drugs, senility), physician maldistribution, governmental and third-party interference, etc.
5. Not enough is known about the educational needs of physicians or how to match individual needs to specific educational content, process, modalities, accesses, etc.
6. No known method exists to show what CME has accomplished or whether it has done what was hoped of it.
7. Compulsory CME may be illegal

in Indiana. (The medical practice act doesn't mention it.)

I think that our sister states which have embraced CME for licensure prerequisites have done so thoughtlessly and prematurely.

For Indiana to undertake compulsory CME for the wrong or inadequate reasons would risk throwing operative voluntary CME programs into a "Mickey Mouse" game of providing only hours instead of quality education.

How do you feel about this?

Meanwhile, back in the Twelfth District we currently have a dedicated group of officers, anxious to transport your thoughts and desires to the ISMA.

ALVIN J. HALEY, M.D.
Trustee

Thirteenth Trustee District



G. BEACH
GATTMAN, M.D.
Trustee

The Thirteenth District meeting was held in Michigan City at the Pottawatomi Country Club on Sept. 10, 1976. The early afternoon activities included golf, tennis and a special ladies' program.

The meeting was called to order by President John Luce. Reports were given by Secretary-Treasurer David Spalding, Blue Shield Representative Kubik and Trustee G. Beach Gattman. Dr. Vincent Santare, president of ISMA, gave a state report, and Dr. John Beeler, president-elect, was introduced. Also present were Chairman of the Board of Trustees Dr. Eli Goodman, Executive Director Donald F. Foy and northern area fieldman Howard Grindstaff.

Dr. Elmer Billings of Elkhart, president-elect of the Thirteenth District for 1977 was present. Election was held for alternate trustee and Dr. Donald Chamberlain was reelected. Dr. David Spalding was chosen president-elect for 1978. Dr. Michael Quinn of South Bend, was elected secretary-treasurer.

Following the business meeting, cocktails and dinner were served and the evening's program was presented by the Greek Dancers from Chicago.

The 1977 meeting will be held at the Elcona Country Club, Elkhart, on Sept. 14. The evening program will be an address by Secretary Earl Butz.

G. BEACH GATTMAN, M.D.
Trustee

Editor of The Journal

The financial accounts of *The Journal* are almost exactly as predicted by the budget. A deficit of about \$27,000 was expected. At the time this report is written it is estimated that the deficit will be close to \$26,000. Most of the fiscal year was spent with a slight positive balance in the Journal account but the June issue and the Roster Supplement are the most expensive monthly expenditures of the year and this year will account for almost all of the deficit. The \$4,000 grant from Eli Lilly and Company for publication of Medical Grand Rounds was a one-time contribution but will be more than replaced in 1977-78 by a \$6,000 grant from the Continuing Medical Education program of Indiana University School of Medicine which will support publication of a monthly teaching article.

The improved financial picture in 1976-77 is due to new items of income such as the Lilly award for publication of Medical Grand Rounds, the Sandoz Prize Award and, in small part, to subsidy payments by authors whose articles occupied space in excess of two pages.

Limitation of articles to two journal pages and the subsidy of longer articles does not produce much income. However, the rule has influenced authors to be brief and to condense their writing. The result has been shorter articles which are easier to read and which conserve space, produce a smaller journal issue and limit the printing bill.

Almost all the longer articles which were accepted prior to the space limitation rule have now been printed. The future will see more and more short articles. In the case of review articles and some others which cannot be shortened, the subsidy, which has been accepted by almost all authors, will contribute to the financial health of *The Journal* budget.

"Seminars from Riley Hospital" is being continued on an abbreviated schedule.

Indiana University School of Medicine will produce and subsidize the publication of a four-page Continuing Medical Education article each month for an indefinite period. A fifth page containing a quiz and facilities for registering the article for Category 1 credit will also appear each month.

Indiana University is the site of one of the four research centers for the National Institutes of Health program for the investigation of cause and treatment of hypertension. This group of investigators and clinicians will produce a two-page article on hypertension and its multiple aspects for publication each month for a period estimated, at the present time, to be two years or more.

The Journal was the subject of a readership study conducted by David Labson of Health Industry Research. The February 1977 issue was the target. Forty one percent of the 150 questionnaires were returned, a phenomenon which, in itself, is highly complimentary. Readership, both for scientific content and for advertising messages, was high and was rated by Mr. Labson as excellent.

The historical and museum articles by Dr. Charles Bonsett, and several other writings on medical history, have, very adequately, satisfied the historical mission of *The Journal*.

FRANK B. RAMSEY, M.D.
Editor

Delegates to AMA

Officers and the Indiana delegation to the American Medical Association attended both meetings of the American Medical Association which were held following the October 1976 Annual Meeting of the ISMA. They represented the ISMA in reference committees and in the AMA House on vast numbers of issues which were considered by delegates from every state medical association.

The Annual Meeting of the AMA was held in San Francisco June 18-23, 1977, and the Clinical Conference convened in Philadelphia, Dec. 4-8, 1976.

This report will give a few of the highlights on the Philadelphia Conference and will address itself to more detail on the annual session in San Francisco.

Through the efforts of the delegation, assisted by officers of the ISMA Auxiliary, the delegation was successful in re-electing Patrick J. V. Corcoran, M.D., Evansville, to the Council on Medical Education. Additionally, John W. Beeler, M.D., president of ISMA, who was elected president of the Organization of State Medical Associations' Presidents at the Philadelphia convention, will continue in this post until June 1978.

Additionally, Steven C. Beering, M.D., dean, Indiana University School of Medicine, was elected chairman of the AMA Medical School Section which represents 87 schools, and Lowell H. Steen, M.D., Hammond, member of the AMA Board of Trustees, was elected to the Executive Committee of the AMA.

A total of 5,210 people, including 2,806 physicians, registered for the AMA's last Clinical Convention ever, in Philadelphia.

The five resolutions reviewed by the ISMA Board of Trustees and submitted to the American Medical Association's House of Delegates met with a variety of actions by the AMA House which convened Dec. 5 through 8.

Two of the resolutions were adopted. They asked for mandatory use of hockey helmets by all professional hockey

leagues and discontinuance of participation in group insurance programs for any physician not a member of the American Medical Association. This latter resolution also requested that husbands and wives of deceased physicians be allowed to continue their insurance coverage under the AMA group policies.

The one resolution dealing with immunity in utilization review was referred to the Board of Trustees of the AMA. The reference committee in its report stated that they "echoed the concern of the resolution, but had questions as to the practicality of a legislation solution . . ."

Generic substitution of a prescribed drug was amended and adopted. The substitute resolution read as follows:

RESOLVED, That the American Medical Association reaffirm its opposition to the revision of state laws and pharmacy regulations that prohibit unauthorized substitution of prescription drug products as contrary to the public interest; and be it further

RESOLVED, That all physicians be urged to supplement medical considerations with cost considerations in making the selection of the drug of choice for an individual patient and become well informed about the quality and efficiency of prescription drug products available from multiple sources; and be it further

RESOLVED, That physicians indicate by writing prescriptions by the generic name when the selection of the source may be delegated to the pharmacist.

Resolution 48, also introduced by Indiana, was not adopted but previous action of the House of Delegates on the subject was reaffirmed. The resolution asked that the American Medical Association exert the strongest possible influence on the Bureau of Health Insurance of the Society Security Administration to retain the original concept of the Medicare law and reestablish an equitable payment mechanism for physicians' services. The reference committee pointed out efforts had been under way for some time to carry out the objective of this resolution.

A substitute amendment submitted by the Georgia delegation was referred to the Council of Medical Services and read as follows

"Since division of states into geographical areas for payment purposes under Medicare results generally in lower fees for rural physicians, and since lower fees tend to produce a negative incentive to physicians to locate in rural and thinly populated areas, the AMA should make every effort to remove the statutory and regulatory requirements for delineation of fees according to geographical areas."

Major focus of attention at the meeting was on a national health insurance bill and its introduction by the AMA.

The Indiana delegation, as instructed by the Board of Trustees, voted against introduction, but the House of Delegates of the AMA reaffirmed its support of a bill by a vote of 181 to 57.

As was pointed out, the vote was a convincing victory for the AMA Board and decisive defeat for the more conservative members of the House.

The delegates, in effect, decided that political realities demanded AMA continue to have a voice in the coming debate of NHI—expected to heat up with the advent of the Carter administration and a Democratic congress—rather than make an all-out fight against any and all forms of NHI.

The NHI debates were THE issue at the 1976 Clinical Convention, providing four hours of testimony before a reference committee and two hours of debate on the House floor.

The president of the American Medical Association strongly urged members not to "turn their backs" on the national health insurance (NHI) debates.

"If we are to offer nothing in the way of NHI legislation," Richard E. Palmer, M.D., told the delegates, "we run the terrible risk of getting clobbered with everything," referring to the mandatory, comprehensive Kennedy-Corman NHI bill. The final vote on the issue was nearly identical to the PSRO vote (185-57) taken in Chicago in 1974. Many of the same faces that opposed PSRO also opposed NHI. It would appear that the liberal-conservative ratio in the House has not changed in the past two years.

The AMA's Annual Convention in San Francisco was one of the most successful in recent years—a total of 15,399 people, including 6,601 physicians, registering for the scientific program and sessions of the House of Delegates.

Nashville, Tenn., urologist Tom Nesbitt, M.D. was chosen president-elect of the American Medical Association by acclamation of the House of Delegates in San Francisco.

The 54-year-old urologist has been speaker of the House for four years. He ran unopposed for the AMA's top office.

Former Vice Speaker William Y. Rial, M.D. was elected speaker of the house, also by acclamation. Dr. Rial, 58, is a family physician in Swarthmore, Pa.

The Indiana delegation introduced resolution 38 on "Confidentiality of Physician and Patient Data" which was minimally amended and adopted by the AMA House. The resolution asked that the AMA, through its proper committees and councils establish:

1. Ethical guidelines which define procedures for the management of

a computerized patient data base.

2. Ethical guidelines which define procedures which control the access to clinical data and limit access to the computerized data base.
3. An accrediting agency for computer service bureaus to reassure patients that their information will not be misused.

The minor change was on item three, the AMA House changed the third word "agency" to "guidelines."

Considerable testimony in the reference committee and on the House floor was voiced by Indiana delegate George Lukemeyer, M.D., in disapproval of the AMA policy regarding HR2222 which classifies residents as hospital employees under the National Labor Relations Act with the capacity of negotiating for wages and other benefits of institutional employment.

The AMA House, however, reaffirmed that housestaff are both students and employees and are entitled to bargaining rights under the National Labor Relations act.

In a contentious discussion rivaled only by the debate over national health insurance, delegates approved a reference committee recommendation that this dual role is not mutually exclusive and does not detract from medical education.

In recommending continued support of this policy, the house backed the reference committee's statement about the "realities of the residency program."

Key issues discussed included national health insurance—or "comprehensive" health insurance, as delegates have now decided to call it—the Food and Drug Act, the Health Planning Act, the Health Professions Educational Assistance Act, and proposed ceiling on hospital costs.

Discussion of each included calls from the more conservative members of the House for all-out fights against the government. But delegates eventually decided that the best means of trying to solve the medical profession's problems with government is to support the previous stands taken by the House and the actions of the Board of Trustees in trying to implement those stands.

For the third straight session of the House, national health insurance was the main topic. The House reaffirmed its support of the AMA's proposal for national health insurance, instructed the board to assure that the proposal will not in any way lead to the "nationalization" of American medicine, and, finally, urged that the term "comprehensive," rather than "national," be used in describing AMA's health insurance proposal.

The case for retaining an AMA proposal on NHI was stated during reference committee hearings by Joe Boyle, M.D., an AMA trustee from California. Referring to the speech given earlier to AMA by HEW Secretary

Joseph Califano, Dr. Boyle said, "We know the (Carter) Administration is out to get us; we just don't know how yet. We had better heed the warnings and keep AMA involved in the discussions."

With the deadline approaching for the implementation of Professional Standards Review Organizations, the American Medical Association House of Delegates acted in San Francisco to clarify AMA policy on PSRO.

Some physicians continued to resist what they considered the imposition of PSROs. Milton A. Kamsler, Jr., M.D., from San Mateo County, Calif., which rejected voluntary establishment of a PSRO, asked the AMA to urge a halt to the program and insist on an audit of PSROs.

The house subsequently adopted an amended resolution that encourages physician sponsorship of PSROs in areas currently without such an agency. The resolution also proposed criteria for physician participation in "alternate PSROs," those that might be imposed on areas.

General policy guidelines on the ethics of physicians testifying as "expert witnesses" in malpractice cases were approved by the House of Delegates in San Francisco.

AMA policy will now say that "expert witness" physicians should be professionally qualified, in the judgment of their peers, to provide the testimony sought in malpractice cases.

Further, the AMA expressed its concern over physicians who are hired as expert witnesses as part of their occupations, and condemned those who give "false or misleading" testimony or misrepresent their qualifications.

Hospitals and medical staffs should have adequate liability insurance, and should work out cooperation plans for handling suits, but choice of insurance coverage should remain the independent responsibility of each, the House of Delegates ruled.

The measure, approving a Board of Trustees report, was taken in place of a resolution from last year's Dallas convention that sought rules to be set up requiring minimum insurance levels and mandating cooperation in lawsuits.

The resolution had sought to avoid the sometimes bitter conflicts between hospitals and physicians when both are named defendants in malpractice suits.

There may be a full-time president in AMA's future, but nobody knows when, how or who.

Delegates debated whether the Association needs a full-time president, whether such a president should also be the chief executive officer, and whether the House or the Board should select such a president.

After hours of reference committee testimony and debate on the House floor, the issue was referred to the Board for

further study, with the proviso that the House wants to continue to name the president of the AMA. A report is to be made at the 1977 interim meeting.

AMA dues will continue to be \$250 a year for regular members, \$35 for residents, and \$15 for medical students, for the time being, the House of Delegates decided.

When AMA regular dues were more than doubled in 1975, the delegates ordered the Board of Trustees to review the dues level at each Annual Convention, with an eye toward reducing them when the AMA's financial status permitted it.

The Association is in much better financial shape now, according to the official auditor's report presented to the House of Delegates, but the Board recommended that dues not be changed now.

Any doubts about the direction of the Carter Administration's health policy were dispelled during the AMA's annual convention in San Francisco.

First, Joseph Califano Jr., secretary of the U.S. Department of Health, Education, and Welfare, told AMA delegates, "National health insurance to protect all Americans from the crushing burden of medical expenses is essential."

The health care industry, Califano said, must be restructured, "to organize health resources more effectively, distribute health care benefits more equitably, emphasize prevention and primary care, and establish a fair and effective system of national health insurance."

Second, the HEW secretary's advisory committee on NHI held the first of its regional "road shows" immediately prior to Califano's address to the AMA, and it is apparent from the paces the 36 member committee is being put through that its final recommendations are meant to mirror the impressions Califano shared with the AMA.

Because current statutes and court opinions contain flimsy guidelines for physicians on the medical management of terminal illness, the American Medical Association's Judicial Council adopted a recommendation for a firm stand on the right-to-die issues.

Mercy killing or euthanasia is contrary to public policy, medical tradition and the "most fundamental measures of human values and worth," the council reported at the annual convention in San Francisco. This stand is an affirmation of previous AMA policy.

When there is irrefutable evidence that biological death is imminent, it is the patient's decision (or his family's) to request the withdrawal of extraordinary means to prolong his life, the council said.

The physician's opinion, however, should not be discounted, the council added. "The advice and judgment of the physicians involved should be readily

available to the patient and his family," the report stated.

The House of Delegates urged the AMA to hire a physician part-time in the Association's Department of Negotiations, over the strong objection of the Board chairman and the executive vice president.

The Missouri delegation had introduced a measure calling for the AMA to hire a physician full-time in the negotiations department, but later modified it to part-time only, paid on a per-diem basis.

Board Chairman Raymond T. Holden, M.D., voiced strong opposition to the resolution, saying that hiring of staff members should be entirely under the control of Executive Vice President James H. Sammons, M.D. Such an action by the house would be disruptive to effective management of the AMA staff, he said.

The House modified the measure to say that the AMA "may" hire a part-time physician for the negotiations department, and passed it as amended.

Dr. Sammons, after the house action, warned strongly that House intrusion into staff policy would be detrimental to the AMA. He explained that the resolution had been offered after the Missouri delegation had suggested an unnamed Missouri physician be hired on the staff. The physician in question would be considered, Dr. Sammons said, if the AMA decided that a physician was needed in the negotiations department.

Medicare continues to create problems for practicing physicians, one of the most frustrating of which is the federal release of physician reimbursement lists that are plagued with inaccuracies.

One of the several Medicare-Medicaid related resolutions and reports adopted by the AMA House of Delegates urged the officers and staff of the AMA to investigate all possible avenues, including legislative action, that might prevent the further release of such lists.

Laetrile is a substance that has no proven value as a drug, the American Medical Association House of Delegates said at its annual meeting in San Francisco.

The position statement came in the wake of action by nine state legislatures in the last two months legalizing the use and administration of the apricot extract, contradicting Food and Drug Administration policy. Several states have also approved the manufacture of the substance.

The new AMA position buttresses policy handed down by the House at last winter's Clinical Convention.

The public should be warned about "the danger in delay of diagnosis and treatment of malignancies by methods not generally recognized by the medical profession as beneficial and effective," the delegates said.

In addition, the delegates stated in 1976 that "the use of amygdalin (laetrile) exploits the victims of malignancies and their families by preying upon the emotions of the hopelessly ill, in some cases for the profit of the unscrupulous."

The American Medical Association will continue to oppose mandatory patient package inserts for all drugs approved for marketing by the Food and Drug Administration.

Physicians testifying during reference committee hearings at the Annual Convention said that the inserts might aggravate patient non-compliance as well as instigate unnecessary alarm through misinterpretation of pharmaceutical companies' listed contraindications.

The major concern expressed by physicians during debate on a resolution that urged repeal of the Delaney Amendment (to the Food Additive Act) was that artificial dosages used for experimental purposes bear no relation to human consumption.

The AMA, in an amended resolution, supported passage of legislation that would change the Food Additive Act "to require evidence based on scientifically reproducible studies on the association of food additives with an increased incidence of cancer in animals or humans at dosage levels related to amounts calculated as normal daily consumption for humans."

In some of the other activities the House of Delegates:

- Referred to the board for further consideration a resolution calling for the AMA to prepare policies and strategies to deal with strikes, lockouts, job actions, and other work stoppages that affect quality and availability of medical care.
- Endorsed the concept that the number of complete on-site hospital reviews be reduced to a minimum and that they be comprehensive enough to supply data to all legitimate agencies.
- Referred a resolution asking the AMA to develop and advocate proposals to permit hospitals to reclassify a patient's status in short-term hospitals, where surplus beds exist, to a "skilled nursing" level.
- Referred a resolution asking the AMA to notify members that attending physicians are not required or legally responsible for certifying and recertifying the need for hos-

pital care for Medicare and Medicaid patients.

- Resolved that all AMA members adhere to the principle of due process, as specified by the AMA and JCAH, in any instance in which an AMA member passes judgment on any other member relating to professional ability, honor, or reputation.
- Supported the establishment of community programs for blood pressure monitoring as part of a national effort to combat hypertension.
- Supported general prison reform and the participation of prisoners in clinical studies of new drugs, provided prisoners are volunteers who have given informed consent.
- Urged inclusion of medical treatment for alcoholic and chemically dependent patients in federal employee health insurance.
- Recommended efforts to enact natural legislation to confirm the profession's authority to develop and use relative value studies.
- Urged that mass screenings of school children, particularly in fragmented organ system screening programs, be undertaken only with the approval of the local medical society.

The AMA must remain strong if it is to continue to be a counterweight to federal intervention, particularly on national health insurance, said AMA President John Budd, M.D.

In his inaugural address, Dr. Budd called the AMA "a citadel for the survival of voluntary action, as opposed to the expanding power of centralized government."

Dr. Budd warned of the vicious circle of "a decline in the people's sense of power and the growth of federal power—unless groups like AMA resist."

A case in point, the AMA official said, is the government's effort to federalize medical care into a monolithic system. In making his point, Dr. Budd coined a new name for the AMA's proposal on NHI: "people's health insurance."

Delegates:

PATRICK J. V. CORCORAN, M.D.
PETER R. PETRICH, M.D.
JAMES A. HARSHMAN, M.D.
ROSS L. EGGER, M.D.
MALCOLM O. SCAMAHORN, M.D.

Alternate Delegates:

THOMAS C. TYRRELL, M.D.
MARVIN E. PRIDDY, M.D.
GEORGE T. LUKEMEYER, M.D.
GILBERT M. WILHELMUS, M.D.
EVERETT E. BICKERS, M.D.

Reports of Committees

Future Planning

The Future Planning Committee held five meetings this year on the following dates: Dec. 15, 1976; Jan. 19, 1977; Feb. 23, 1977; March 13, 1977, and May 11, 1977, all at the Association headquarters.

Following through with the program outlined last year, the Future Planning Committee approved a proposed protocol for conducting a feasibility study of potential computer applications. The following objectives were to be accomplished in Phase I of the study:

1. Analysis of technical and economic data processing requirements to support current and expanded specifications for membership record processing and accounting systems. This included the current AM-CAP system and the alternatives for in-house data processing capability.
2. Identification of new services that ISMA could make available to members as a result of having its own computer capability. These include:
 - a) Membership dues billing and recordkeeping
 - b) Reminder notices to delinquents
 - c) Generation of special letters
 - d) Printing of address labels for all mailings, including *The Journal*
 - e) Bookkeeping, including monthly printouts
 - f) Recordkeeping for continuing medical education
 - g) Patient billing systems.
 - h) Medical office bookkeeping systems
 - i) Assistance to county society business bureaus

The objectives of Phase II of the study were considered long-range in nature and included:

- a) Provide technical assistance to ISMA leadership to assist in developing and implementing a long-range planning methodology for future information processing needs and desires.
- b) Definition of the parameters of a system that could enable ISMA to make data services available to government agencies, PSROs, HSAs, etc. This would include identification of specific participants in an ISMA medical data base.
- c) Development of a pro forma statement of income and ex-

penses related to the implementation of such a program.

This plan was presented to the Board of Trustees on Aug. 29, 1976 and approved. The protocol was sent to a number of computer firms for an estimate. Membership Information Services for M.M.S., Inc., of Chicago received the contract to do the study, which was initiated on Oct. 22, 1976. When completed, the feasibility study included a summary of a report for Phase I, and also for Phase II.

The report indicated that the development of an internal computer capability by ISMA is logically sound and economically feasible. It can assist ISMA in the satisfaction of the following goals:

- 1) Improvement of internal ISMA operations
- 2) Establishment of ISMA as the medical data administrator for Indiana
- 3) Discovery of new sources of revenue
- 4) Provision of new benefits of ISMA membership.

It can guarantee ISMA's position of authority in Indiana health care, and protect the right of the physician to control the policies of medicine. When presented to the Board of Trustees of the Indiana State Medical Association, the development of a physician data base was approved. The Board also recommended the formation of three committees, physician data base, patient data base, and a computer committee to followup further on the feasibility study recommendations.

The undertaking of a membership opinion poll was also approved by the Board of Trustees this past year. A poll was developed, printed and ready for distribution in time for the annual meeting in October 1976. There were one thousand seven hundred twelve (1,712) responses to the questionnaire. On the basis of these responses the committee recommended:

- 1) That AMA membership not be mandatory
- 2) Investigate offering the types of insurance coverage designated in the questionnaire
- 3) Encourage physicians to participate in continuing medical education
- 4) Investigate the possibility of offering the membership the equipment at special prices, as indicated in the questionnaire
- 5) The Editorial Board consider a revised format for *The Journal*
- 6) The News Flash be continued in its present format
- 7) Tel-Med become financially self-supporting
- 8) A modest registration fee be charged for the ISMA annual convention
- 9) Continue efforts being made in public representation

- 10) Proceed to develop programs in the areas of practice management and consultative services.

The membership poll was very successful in that it allowed ISMA members to present to the Board of Trustees their thoughts. On the basis of this poll, the Board of Trustees has discontinued Tel-Med with a savings to the membership of approximately sixty-seven thousand dollars (\$67,000.00) annually.

If the ISMA is to remain a major and viable spokesman for all physicians in Indiana, it is in definite need of some form of a physician and probably patient data bank. The Board of Trustees of the Indiana State Medical Association would also like to develop a system for obtaining the ideas and feelings of Indiana physicians rapidly and accurately in order to facilitate knowledgeable decision making.

The Future Planning Committee of the Indiana State Medical Association recommends that the Board of Trustees continue to pursue the concepts embraced in the computer feasibility study.

STANLEY CHERNISH, M.D.
Chairman

PETER R. PETRICH, M.D.; E. HENRY LAMKIN, JR., M.D.; JACK SHANKLIN, M.D.; FRED W. DAHLING, M.D.; RANDY LEE, M.D. (resident); WALTER HUNTER (student).

Grievance

The Grievance Committee has met twice—April 16, and June 11, 1977. At the April meeting four new cases were reviewed and appropriate action taken. Four old cases were filed and six other miscellaneous cases were reviewed as to further disposition.

On June 11 the committee reviewed five new cases, filed five old cases and five other miscellaneous cases were discussed as to further disposition.

There will be at least one further meeting of the Grievance Committee before our October state meeting.

The chairman would like to offer to the membership the consensus of this committee:

"Most of our problems are in the area of patient-doctor communications. If we all could take a few extra minutes to try and truly communicate with our patients and their families, most of the complaints we receive would not happen."

We would like to offer our thanks to Kenneth W. Bush and especially to Elsie Reid for assistance to this committee.

G. BEACH GATTMAN, M.D.,
Chairman

GEORGE T. LUKEMEYER, M.D.; WILLIAM G. BANNON, M.D.; MARTIN J. O'NEILL, M.D.; ROBERT J. MARVEL, M.D.

Reports of Commissions

Constitution and Bylaws

The House of Delegates in October 1976, adopted reorganization of the Constitution and Bylaws of the Indiana State Medical Association and recommended changes in both the Constitution and the Bylaws.

In accord with the 1975 Constitution and Bylaws (Article XIV—Amendments), the revised Constitution and Bylaws have been published twice in *The Journal of the ISMA* (December 1976, and June 1977) and will be presented to the House of Delegates for final vote during the October 1977, Convention. If this document is passed by a vote of two-thirds of the delegates present at the Convention, it is considered adopted. The Commission on Constitution and Bylaws will provide the House with printed copies of this document for their further study.

For additional clarification, throughout the printed copy of the Constitution and Bylaws there are words and phrases in parenthesis. These are the words and phrases which the House elected to delete from the Constitution and Bylaws in October 1976.

Those words and phrases which are italicized are the words and phrases which the House in 1976 elected to add or change in the Constitution and Bylaws.

Additionally, the Commission on Constitution and Bylaws met during 1977 and recommends to the House of Delegates the following revisions for consideration by the 1977 House of Delegates:

CONSTITUTION

Article VII—Trustees

Add the following sentence to this Article:

"The Board of Trustees shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed by the law governing directors of corporations or as may be prescribed in the Bylaws."

Article IX—Funds, Dues and Assessments
It is recommended that this article be completely deleted and written as follows:

"Funds may be raised by annual dues or by assessment of the active members on recommendation of the Board of Trustees and after approval of the House of Delegates, or in any other manner approved by the Board of Trustees as provided in the Bylaws."

BYLAWS

DIVISION ONE—MEMBERSHIP

Chapter II—Dues, Funds and Assessments

Section 1—Dues, A(d), second paragraph

Parentheses () indicate recommended deletions; Underlined words and phrases indicate recommended changes.

"Funds (may) shall be appropriated by the (House of Delegates) Board of Trustees to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions (appropriating funds) recommending the appropriation of funds by the House of Delegates must be referred to the Board for (approval) recommendation before final action is taken (thereon) by the House of Delegates."

DIVISION TWO—ANNUAL CONVENTION ACTIVITIES

Chapter IV—Specialty Sections

Section 1—Official Sections

Delete Item t, which reads "Any other sections that hereafter may be provided for by the House of Delegates." and the sentence immediately following which is a duplication.

The last sentence which reads "All proposed sections . . ." should read, "All future sections will be formed . . ."

Section 2—Officers

In the fourth line "Committee on Scientific Work" should be deleted and replaced by "Commission on Convention Arrangements . . ."

DIVISION THREE—BUSINESS AND LEGISLATION

Chapter V—House of Delegates

Section 8—Reference Committees and Committee on Rules and Order of Business

A. Reference Committees.

Third paragraph, first sentence, to read as follows with the addition underlined: "Each committee shall consist of at least five members, three of whom including the chairman shall be delegate-members of the House, unless otherwise provided."

Section 9—Election of Officers

At the end of the third paragraph, add the following: "The Treasurer and Assistant Treasurer shall be nominated by the Board of Trustees from the membership of the Indiana State Medical Association."

Chapter VII—Board of Trustees

Section 4—Meetings and Terms

Add the following sentence to the last paragraph in this section:

"No alternate trustee shall be eligible to serve longer than two (2) consecutive three-year terms. The time given to serv-

ing an unexpired term shall not be considered in determining the period within which a trustee or alternate trustee may serve consecutively."

Section 6—Organization and Duties

Add the following sentence to the first paragraph in Item A:

"The Chairman of the Board of Trustees shall be an ex officio member of all ISMA standing commissions and committees."

Chapter VIII—The Executive Committee

Section 1—Composition

Following the first sentence in this section, add: "If the Executive Committee is unable to select a chairman within thirty (30) days after the final meeting of the House of Delegates, then a meeting of the Board of Trustees shall be called and a chairman of the Executive Committee shall be selected by the Board of Trustees."

DIVISION SIX—MISCELLANEOUS

Chapter XVIII—Amendments

In Section 1, in the third line following the word "convention" remove the comma and replace it with a period, deleting the remainder of the sentence.

Following this, add:

"Amendments to the Bylaws must be submitted to the Commission on Constitution and Bylaws 30 days in advance of the Annual Convention. These amendments are eligible for passage after lying on the table for one day. Bylaw amendments presented to the House of Delegates at the time of the Annual Convention will not be eligible for consideration by the House of Delegates until the next annual meeting."

JOHN B. GUTTMAN, M.D.
Chairman

CLAUDE JAMES MEYER, M.D.; IVAN T. LINDGREN, M.D.; C. G. CLARKSON, M.D.; I. E. MICHAEL, M.D.; JOHN SAALWAECHTER, M.D.; FRANK M. STURDEVANT, M.D.; ROBERT M. BROWN, M.D.; WILLIAM R. CLARK, SR., M.D.; LESTER H. HOYT, M.D.; JOHN RECORDS, M.D.; WALLACE SCEA, M.D.

Legislation

The 100th General Assembly and the May 23, 1977, Special Session of the General Assembly were very active periods for the ISMA Commission on Legislation. The Commission met four times during some very severe weather, but the attendance was excellent. Approximately 1,200 bills were introduced and 147 identified as having a potential impact upon the practice of medicine in Indiana. The ISMA Legislative Commission considered the following important health-related legislation:

1. **HB 1664—PEER REVIEW (Resolution 76-23)**
This bill provided immunity from civil tort prosecution for those persons participating in organized peer activities performing evaluation of provider qualifications and patient care rendered. The bill was signed by the Governor.
2. **HB 1808—CATASTROPHIC INSURANCE (Resolution 76-24)**
This bill was introduced by Dr. E. Henry Lamkin, majority floor leader, House of Representatives, in response to the Indiana State Medical Association House of Delegates' Resolution. The legislation required the State of Indiana to solicit bids for catastrophic insurance from private carriers and make the insurance available to citizens of Indiana. The bill was not considered by committee.
3. **HB 1433—DEFINITION OF DEATH (Resolution 76-29)**
Representative Lamkin introduced legislation which defined death as cessation of spontaneous brain activity when the patient was on artificial support equipment. The bill passed the House but was not considered in the Senate.
4. **HB 1050/HB 2076—GENERIC SUBSTITUTION**
The House of Delegates directed the ISMA to oppose legislation which allowed for generic substitution of prescription drugs. Two bills were introduced and neither received a committee hearing.
5. **HB 1418—CERTIFICATE OF NEED (Resolution 76-28)**
The House of Delegates directed the ISMA to oppose any certificate of need legislation. This bill required physicians to seek a certificate of need prior to the construction of facilities costing more than \$100,000 from the local HSA. SB 542 required health care facilities to be subjected to Section 1122 of the Social Security Act (Medicare/Medicaid Reimbursement for Capital Expenditures). The definition of a health care facility was expanded to read the same as the certificate of need definition and, therefore, ISMA opposed the bill. Neither bill passed.
6. **MEDICAL EXAMINER**
The Commission requested outside counsel to draft legislation for the removal of the coroner's office as a constitutional office substituting it with a qualified physician medical examiner. A vehicle bill was reserved for this purpose, but the content was not provided.
7. **HB 1439—DEDICATED FUNDS FOR LICENSING BOARDS**
The Commission requested legisla-

tion for a change in the funding of the Medical Licensing Board. This bill was introduced to provide dedicated funding for licensing boards. The bill passed but was amended to provide for the conduct of a study to determine the feasibility of the dedicated funding method for the licensing boards.

8. **HB 1427—PHYSICIAN ASSISTANTS**

The Commission supported the amendment of the Medical Practice Act which defined the physician assistant and generally outlined the duties which he could perform under the supervision of his employing physician. The final language omitted any provision for a so-called Duffy Amendment. The bill was signed into law by the Governor.

9. **HB 1637—MEDICAL REVIEW PANEL**

The ISMA supported the technical amendments introduced by the Governor's Study Commission on Medical Malpractice this legislative session. The amendments provided a mechanism by which each side in a malpractice suit selected a member chairman within a certain number of days. The legislation was signed by the Governor.

10. **HB 1366—RIGHT TO DIE**

This bill allowed a patient to direct the physician to allow termination of life support systems in terminal cases. The bill received a hearing but was not reported out of committee.

11. **HB 1405—LAETRILE**

The Governor vetoed this bill because of the significant changes made in the conference committee report. The present statute permits laetrile treatment in lieu of regular scientifically proven treatment. Additionally, laetrile can be used as a dietary supplement. The conference committee report further amended the legislation by stripping the State Board of Health and the State Pharmacy Board of any regulatory authority. The General Assembly overrode the Governor's veto on April 30, 1977. The bill became law on June 1, 1977.

An added tool for the Legislative Commission this year was the timely addition of Mr. Richard King as Legislative Analyst. Mr. King worked many hours in keeping track of the movement of bills through the House and Senate committees. He also ably explained to the legislators ISMA's position on bills which concerned the practice of medicine. The Commission wishes to thank

him for his efforts and we look forward to next year's session of the Legislature.

I would like to thank the members of the Commission and the Board of Trustees for their attendance and input at the meetings in spite of the bad winter. I believe that holding combined meetings of the ISMA Commission and the IAFP Legislative Committee was most beneficial.

The Commission also wishes to thank Dr. E. Henry Lamkin for the help and leadership he provided in guiding important medically related legislative issues through the 100th session of Indiana's General Assembly. The Commission believes that this session was a most successful one for ISMA, and is well aware that this success could not have been accomplished without his help.

Last, but not least, the Commission wishes to thank Mr. Foy and the entire ISMA staff for their cooperation and endless hours of work which made the Commission's meetings possible as well as successful.

LEONARD W. NEAL, M.D.
Chairman

JAMES A. MARVEL, M.D.; PAUL J. WENZLER, M.D.; PETER H. LIVINGSTON, M.D.; WILLIAM F. BLAISDELL, M.D.; WILLIAM STRECKER, M.D.; JOHN A. DAVIS, M.D.; JOHN G. PANTZER, M.D.; RICHARD L. REEDY, M.D.; JOHN A. KNOTE, M.D.; RICHARD L. GLENDENING, M.D.; JERRY L. STUCKY, M.D.; MALCOLM O. SCAMAHORN, M.D.; JOHN B. WHITE, JR., M.D.; PHILIP N. ESKEW, M.D.; PELAYO B. CABRERA, M.D.; JOSEPH M. BLACK, M.D.; ERNEST R. BEAVER, M.D.; RONALD BLANKENBAKER, M.D.; MRS. R. M. SCHLEINKOFER (Auxiliary); MRS. F. O. MACKEL (Auxiliary); WILLIAM POND (Student Member).

Medical Education

The Commission on Medical Education and its Committee on Accreditation held three meetings this year. The following actions were taken:

1. New hospitals and specialty societies have been surveyed and CME accredited. Hospitals initially accredited for a two-year period are now being resurveyed and accreditation renewed. Several societies made application, but action was deferred pending additional information.

CME accreditation or reaccreditation was approved for:

* Indiana Philippine Medical Society
Indiana Chapter American College of Surgeons

*Indicates reaccreditation.

* Huntington Memorial Hospital
Good Samaritan Hospital, Vincennes

Fort Wayne Anesthesia Society

* St. Mary's Medical Center, Gary
Scheduled for review by the Accreditation Committee and the Commission on Medical Education at the Aug. 28, 1977, meeting are:

Indiana State Board of Health seminars

Indiana Academy of Family Physicians

* Gary Methodist Hospital

* St. Catherine Hospital—East Chicago

* St. Joseph Hospital—Kokomo
Welborn Baptist Hospital—Evansville

St. Joseph County Medical Society

2. Scientific programs for ISMA State Convention were reviewed, thus permitting attendees at these scientific programs to include those category 1 hours in their PRA application. Hours allowed will be published in *The Journal* for each program. Validated cards will be available to attendees for their CME records of programs attended. Liaison members of the Commission on Medical Education were named to meet with the Commission on Convention Arrangements to aid in providing Category 1 accreditation.

3. In efforts to further stimulate interest in CME and recognize those physicians who are participating the Commission has:

3.1 Issued a letter to all Indiana physicians urging them to participate in CME and to apply for the Physician's Recognition Award. This will be enclosed with the 1977 PRA Booklet and Application to be mailed by the AMA in August.

3.2 Obtained printouts of all PRA recipients in Indiana each month. Issued a gold Distinguished Membership card and letter of congratulations to each ISMA member listed.

3.3 Published names of PRA recipients in *The Journal* each month.

3.4 Placed insert in *The Journal* to be detached and used for record of CME hours each physician attains. Similar insert will be repeated in a fall 1977 issue and will repeat the PRA requirements.

3.5 Purchased publications prepared by the Illinois Council on CME which will be offered to smaller hospitals and to DMEs of accredited hospitals. "How to Start a CME Pro-

gram," "Case Discussion and Problem Solving" and "Planning CME Programs That Fit Staff Interests."

4. Facing the very controversial subject of mandatory CME for ISMA membership and/or legislated CME for recertification, the Commission has recommended that the Board of Trustees consider a three-year voluntary CME requirement for ISMA membership, followed by a possible mandatory requirement.

5. The Commission likewise has recommended to Dr. Beaver of the Indiana Licensing Board that any regulations they develop on relicensure conform in pattern and time intervals to the AMA's PRA.

6. The following Commission members provided liaison with other groups:

Board of Trustees:

Franklin Bryan, M.D.

Indiana Medical Licensing Board:

Ernest R. Beaver, M.D.

Accreditation Committee:

Eugene Gillum, M.D.

AIDME:

Franklin Bryan, M.D.

Division of Postgraduate Education, I.U.:

John Phillips, M.D.

Convention Arrangements:

Cleon Schauwecker, M.D.

John Roscoe

Indiana Academy of Family Physicians:

Eugene Gillum, M.D.

Student Affairs:

Phillip Doering, M.D.

House Staff:

Gary Wright, M.D.

Commission on Legislation:

Steven C. Beering, M.D.

STEVEN C. BEERING, M.D.
Chairman

ROBERT H. OSWALD, M.D.; DAVID A. BYRNE, M.D.; RICHARD RIEHL, M.D.; LESLIE M. BAKER, M.D.; CLEON SCHAUWECKER, M.D.; JOHN LING, M.D.; DONALD M. SCHLEGEL, M.D.; EUGENE M. GILLUM, M.D.; T. NEAL PETRY, M.D.; NICHOLAS L. POLITE, M.D.; SHOKRI RADPOUR, M.D.; RONALD H. SCHEERINGA, M.D.; WALLACE S. TIRMAN, M.D.; ERNEST BEAVER, M.D.; FRANKLIN A. BRYAN, M.D.; GEORGE ALCORN, ROBERT CHEVALIER, M.D.; EDWIN S. McCLAIN, M.D.; JOHN ROSCOE, JOHN PHILLIPS, M.D.

Subcommission on Accreditation
EUGENE M. GILLUM, M.D.
Chairman

THOMAS SPAIN, M.D.; MICHAEL A. HOGAN, M.D.; DONALD M. SCHLEGEL, M.D.; WILLIAM FECHTMAN, M.D.; WILLIAM D. RAGAN, M.D.;

RAYMOND PIERCE, JR., M.D.; JEFFREY KELLAMS, M.D.; CHARLES HELMEN, M.D.; EMMETT PIERCE, M.D.; STEVEN C. BEERING, M.D.; FRANKLIN A. BRYAN, M.D.; DAVIS W. ELLIS, M.D.; SHOKRI RADPOUR, M.D.; RALPH WILMORE, M.D.; GARY WRIGHT, M.D.; PHILLIP DOERING, M.D.; NEALE A. MOOSEY, M.D.; JOHN PHILLIPS, M.D.; JOHN ROSCOE; JOHN OSBORNE, M.D.

Medical Services

This is a preliminary report of the Commission on Medical Services to meet publication requirements. Completion of Commission activities and resolutions and recommendations will be prepared and submitted by convention time.

The consolidation of preceding commissions' work was continued. Additionally, new areas of endeavor have been sought and evaluated.

VOLUNTARY HEALTH AGENCIES: The annual approval of statewide Voluntary Health Agencies has been discontinued as a commission activity on a regular basis. The services of the ISMA will be available to assist the agencies in areas relating to medical involvement. The ISMA will continue to review, informally, the annual reports of the agencies.

INSURANCE: The concept of an in-house broker was reviewed and felt to be nonproductive currently. Development of a "captive" insurance company would not be advisable at present.

MALPRACTICE: While not directly responsible for this activity, the commission continues to maintain contact with this field, particularly in regard to premiums and also experiences with claims-made type policies.

HEALTH: Health insurance programs were reviewed as best as possible prior to contract renewal. There was an inadequate presentation of utilization experience. The Commission was concerned not so much with the coverage or its major medical provisions, but rather with the quality of claims processing. The commission recommended as an innovation that the ISMA process its members' claims as a form of self-administration. While this recommendation was not accepted, it did result in the appointment of an *ombudsperson* on the Blues company payroll to consult with ISMA members and their dependents on claims problems.

AGING: The Subcommission on Aging has been active under the leadership of Albert Donato, M.D.

1. A roster of directors of Indiana nursing homes is being compiled.

2. Liaison with the Department of Public Welfare concerning nursing home matters and medical care has been developed.

3. The commission is engaged in the study of fees and parameters of Medicaid programs for nursing homes.

COMPUTER STUDY: The commission participated in and reviewed the ISMA computer application study. While an in-house computer would serve well for housekeeping functions, it would seem that in addition to a computer the Association could benefit in its deliberation from the professional services of a data gatherer and analyst of other data systems, such as Blue Shield, HSAs, government medical programs (Medicare and Medicaid) and members' insurance programs.

SPORTS AND MEDICINE: After a complete breakdown in this field of leadership and purpose, the commission has reviewed ongoing ISMA activity in this area and developed new medical leadership. Further details will be refined in the next few weeks and submitted in the supplementary report.

WELFARE: Meetings have been held with Mr. Wayne Stanton, administrator of Public Welfare, and James O. Price, M.D., Director of Medical Affairs, IDPW, regarding the medical field. Meetings have been arranged to study Medicaid and other welfare programs. Studies of the new Medical Management Information System (MMIS) are being made. The new data reporting system has been available for only six months. An ongoing system of evaluating these reports for the purpose of making appropriate recommendations to the administrator on the various programs will in all likelihood be developed.

The chairman wishes to thank staff, guests and particularly the members of the commission for their interest and attendance and valuable input.

LEE TRACHTENBERG, M.D.
Chairman

WALLACE ADYE, M.D.; ROGER F. ROBISON, M.D.; EVERETT E. BICKERS, M.D.; ROBERT O. ZINK, M.D.; PAUL E. HUMPHREY, M.D.; ROBERT R. TAUBE, M.D.; ALBERT M. DONATO, M.D.; THEODORE R. HAYES, M.D.; GERALD BOUGHER, M.D.; R. JAMES BILLS, M.D.; R. WYATT WEAVER, M.D.; JACK W. HANNAH, M.D.; ROBERT R. KOPECKY, M.D.; HAROLD MARSHALL TRUSLER, M.D.; RICHARD B. SCHNUTE, M.D.

Public Information

The Commission on Public Information met in December 1976, March and May 1977.

Once again, the Commission took up the matter of an Accountability Session and, after much discussion, decided to table indefinitely any further debate on this. Instead the Commission voted to initiate, on a trial basis, as part of its function, a review hearing session at each of its meetings for constructive input from appropriate outside agencies and individuals regarding any and all areas of medicine and health care services in the state of Indiana that would relate to ISMA. The Commission will review the information and refer its conclusions to the appropriate commission or committee for information or action. The Commission will reserve the right to accept or reject the requests based on merit and/or availability of time. The Commission expects to start holding these hearings during 1978.

At all three meetings funding for the Tel-Med program was discussed. At the request of the Commission, staff sent letters to several foundations and organizations requesting financial support for the Tel-Med Program, but in each case the response was, "We think it is an excellent program, but we are not able to donate." With the approval of the ISMA Board of Trustees, funding was also solicited from the three HSAs and the State Health and Development Agency. The results were the same. The Commission recommended that the Tel-Med program be continued statewide, without the use of WATS lines, for three months and a record kept to find out if callers outside the Indianapolis area were willing to use the program when they had to pay for the call. The Commission requested a transfer of \$5,000 from its budget to the Tel-Med fund in order to conduct this study. The Executive Committee, with authority from the Board of Trustees, decided the best solution was to discontinue the program and continue discussions with other parties who expressed an interest in taking over the program. The program, much to this Commission's regret, was discontinued on June 6, 1977.

It was noted by the Commission that ISMA's Speakers' Bureau was not being used to the extent that all had hoped it would be. The Commission requested staff to prepare a letter that would be sent to each county society secretary with a brochure from the Hopkins Syndicate, which handles the program for ISMA, requesting them to publicize the availability of the Speakers' Bureau. Thus was done, but the requests for speakers are still below expectations.

Three films on socialized medicine were borrowed from the Louisiana State Medical Association to determine if they

would be worth purchasing. Drs. Acher, Middleton, and Ritz showed the films to non-medical groups in their area and reported a good response. The Commission purchased two copies of each film and their availability was publicized in the News Flash.

The Commission also viewed a 24-minute, 16 mm color film, "Together We Are Something" and decided it could be a useful tool for ISMA's field representatives to use in interesting young physicians to become active in their county and state societies. The film was purchased and the field representatives were requested to develop an effective program to present the film.

A physician survey on Substance Abuse was approved for distribution by the Department of Mental Health with the stipulation that the data from the questionnaire be made available to this Commission for approval of any conclusions. The Commission felt there was a definite need for such information to aid in the planning of clinics and to help motivate funding for substance abuse programs.

At the request of John W. Beeler, M.D., president, ISMA, the Commission was requested to come up with a good statement of opposition to Certificate of Need. The Commission recommended that the Board of Trustees accept Report C of the AMA's Council on Medical Service as ISMA's position on Certificate of Need. It states:

As much as certificate of need is intended to cut costs, avoid duplication, increase accessibility, etc., it can also stifle competition, be extremely time-consuming and expensive, and may not appropriately address the problem of duplication of facilities and services. Competition should be encouraged and new types of incentives should be created for the health and medical care providers. Certificate of need should be more responsible to the public disclosure in order to maintain reasonable cost. Caution should be taken so that particular special interests don't have control of the certificate of need process. Finally, prudent judgment should be the hallmark of certificate of need legislation at all levels.

The Commission also discussed the advisability of publicizing the need for Catastrophic Health Insurance without knowing more about the availability and cost. The Commission was concerned about the claim made by HIAA that 95% of Indiana's population under age 65 had coverage in the amount of \$10,000. Therefore, the Commission decided to table any further discussion until the Medical Services Commission has had an opportunity to investigate the matter and provide this Commission with a report.

The report on Criteria and Standards for Perinatal Health Services was looked at by the Commission and was judged unacceptable in several areas. The Commission felt the report offered solutions without identifying specific problems. The Commission recommended that ISMA's Committee on Perinatal Health Services be requested to review the report again in search of other alternatives to transporting patients and to closing down facilities now available to Indiana patients. At a later meeting the Commission was made aware of the letter James A. Harshman, M.D., chairman of the Board of Trustees, sent to William T. Paynter, M.D., State Board of Health Commissioner, concerning this matter. The Commission sent a letter to Dr. Harshman complimenting and supporting him on his correspondence to Doctor Paynter.

U.S. Standard Certificate of birth, death and a report of induced termination of pregnancy were looked at for format and content at the request of the State Board of Health. The Commission requested sections 12 and 13 on the Certificate of Live Birth be deleted because they were not necessary and invaded privacy.

A report that an award be offered by the ISMA to the physician doing the most Medicaid work as a way to offset

some of the bad publicity in this area was rejected by the Commission.

The Commission also made its selection for the Journalism Awards and for the Physician Community Service Award. These awards will be presented at the Indiana State Medical Association's annual meeting in October.

At the direction of the ISMA Board of Trustees, a seminar on health care costs was discussed at some length at the final meeting of the Commission. Dr. Priddy appointed Dr. Charles Egnatz to chair a special committee of this Commission to look into organizing such a seminar. Dr. Ross Egger and Dr. Albert Ritz, were appointed to the committee with Dr. Priddy, serving as an ex-officio member. The Commission informed the Board of Trustees that it is in favor of such a seminar and requested the Board's approval and direction for site and cost. The Commission will move ahead when the Board has had an opportunity to discuss the matter and respond.

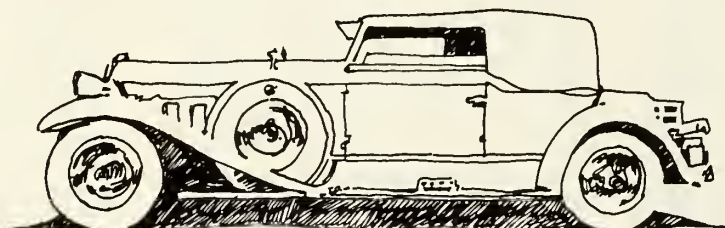
The Commission adopted the Scoliosis Screening Program of the Vanderburgh County Medical Society and sent the material to each county medical society for implementation. *The Journal* was also requested to include an article regarding the necessity for such a program and reminding all physicians to check for scoliosis in children.

Several other letter requests were handled by the Commission regarding: Emergency Medical Information Card, ISMA Membership Decal, Hypoglycemia Club, AMA Public Service Announcements, Immunization, Health and Humanities, Women in Medicine—Oral History Project, Diabetic Exchange List, Names of People and Places Responsible for Newly Developing Technics and Procedures in Different Fields of Medicine in Indiana, and Scriptographic Booklets.

As chairman of the Commission, I wish to thank the members of the Commission for their participation. The meetings were productive and, I feel, will help enhance the public relations of the Association.

MARVIN E. PRIDDY, M.D.
Chairman

ALBERT S. RITZ, M.D.; THOMAS O. MIDDLETON, M.D.; KENNETH E. HINES, M.D.; ROBERT P. ACHER, M.D.; GREG LARKIN, M.D.; RALPH LEWIS REA, M.D.; ROBERT W. HARGER, M.D.; KENNETH J. AHLER, M.D.; CHARLES D. EGNATZ, M.D.; JOHN W. LUCE, M.D.; HARRY G. BECKER, M.D.; ROSS L. EGGER, M.D.; GABRIEL J. ROSENBERG, M.D.; HARRY G. MCKEE, M.D.; MIKE GOLER (Student Member).



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Resolutions

Resolution No. 77-1

Introduced by: Vanderburgh County Medical Society

Subject: ISMA DUES STATEMENT

Referred to:

Whereas, Dues statements for the county medical societies, Indiana State Medical Association, and the American Medical Association are combined into one statement which is sent out by the Indiana State Medical Association; and

Whereas, These statements list both the amount of dues for each organization, and several optional contributions for such programs as the Indiana Medical Political Action Committee, the Tel-Med program, etc.; and

Whereas, All the amounts for both dues and contributions, are added together into one total; and

Whereas, Many doctors, receiving such a statement, assume that the total figure is the amount which must be paid, not realizing that a portion of the total is optional; and

Whereas, This is an inappropriate and demeaning tactic which, in effect, Indiana physicians are misleading and manipulating themselves; now, therefore be it

Resolved, That ISMA modify the form of its dues statements so that dues are listed and totaled separately from voluntary contributions, and it is made clear which amount must be paid to maintain membership, and which amounts are optional.

Resolution No. 77-2

Introduced by: Clark County Medical Society

Subject: OPPOSITION TO NHI

Referred to:

Whereas, The physicians of Indiana have traditionally given excellent medical care under the present system of medical care; and

Whereas, Indiana has consistently taken a stand against any form of NHI, including at the AMA meeting in Philadelphia; and

Whereas, The AMA has again presented a bill for NHI, and

Whereas, the AMA has refused to poll its members on this all important issue despite the pleas of several state associations; now, therefore be it

Resolved, That this House of Delegates instruct the Board of Trustees of ISMA to poll our members on whether or not they want the AMA to withdraw

their bill for NHI and vigorously oppose any NHI bill; and

Resolved, That Indiana ask all other state associations to do the same; and

Resolved, That if these polls reveal that the majority of physicians are of like mind, demand that the AMA follow the dictates of its own membership.

FISCAL NOTE: Estimated cost \$1,300.

Resolution No. 77-3

Introduced by: Fort Wayne-Allen County Medical Society

Subject: STUDY OF WITHHOLDING OF SERVICES

Referred to:

Whereas, A recent nationwide American Medical Association survey indicated the majority of physicians in this country approve of withholding their services under certain selected circumstances in which third party decisions, i.e., private or governmental, impair the sound delivery of medical care for their patients; now, therefore be it

Resolved, That the Indiana State Medical Association undertake a study as to what its overall policy should be in such cases, and what the fiscal problems would be for those physicians and their families; and be it further

Resolved, That the results of this study be presented to the Indiana State Medical Association membership, along with specific recommendations and, further, that the Indiana State Medical Association membership be polled to determine their attitudes toward this matter.

FISCAL NOTE—\$5,000

Resolution No. 77-4

Introduced by: Steuben County Medical Society

Subject: WITHHOLDING OF SERVICES

Referred to:

Whereas, There is a trend developing in third parties to control the health industry by regulating health insurance and hospitals and the activities within the hospitals; and

Whereas, There is a trend by third parties to organize physicians into HMO, IPA, etc., and to encourage hospitals to provide total care including multispecialty outpatient care; and

Whereas, There is a trend to replace the traditional patient-physician relationship with the consumer-provider relationship; and

Whereas, A recent nationwide American Medical Association survey indicated the majority of physicians in this country approve of withholding their services under certain selected circumstances in

which third party decisions, i.e., private or governmental, impair the sound delivery of medical care for their patients; now, therefore be it

Resolved, That the ISMA study the feasibility, effect and legality of the following:

1. The withholding of non-emergency physician services from a few selected hospitals with the purpose of negotiations with those hospitals to affect all hospitals.
2. The refusal to sign selected health insurance company forms by physicians.
3. The establishment of contracts between the medical staff and hospitals.
4. The establishment of a statewide withholding service fund to be made available if needed to physicians to meet their financial responsibilities, and be it further

Resolved, That the ISMA review the effect of the usual and customary program upon the patient-physician relationship and if indicated cause its reform or cancellation; and be it further

Resolved, That the results of this study be presented to the Indiana State Medical Association membership, along with specific recommendations, and further, that the Indiana State Medical Association membership be polled to determine their attitudes toward this matter.

FISCAL NOTE—\$5,000

Resolution No. 77-5

Introduced by: Fort Wayne-Allen County Medical Society

Subject: A MENDMENT OF THE BYLAWS OF THE ISMA TO PROVIDE FOR VETERANS ADMINISTRATION MEMBERSHIP

Referred to:

Whereas, The new ISMA Bylaws provides for a category of members entitled "Military Service and Public Health Service Members" in Chapter 1, Section 3, Paragraph G; and

Whereas, There are other doctors living and practicing in other government agencies in hospitals in Indiana, namely the Veterans Administration, not provided for within the Bylaws; now, therefore be it

Resolved, That Chapter 1, Section 1 of the Bylaws be amended by adding "Veterans Administration Member" between "Military Service Member" and "Public Health Service Member"; and

Chapter 1, Section 3, Paragraph G be amended to include "Veterans Administration Member" so that this section would read "Military Service Members, Veterans Administration Members and Public Health Service Members. Any

person who is actively engaged in the military service, veterans administration or public health service should be eligible for membership in the Association with payment of regular dues; they shall receive THE JOURNAL."

Resolution No. 77-6

Introduced by: Huntington County Medical Society

Subject: COMPULSORY POLITICAL MEDICINE
SPONSORED BY AMA

Referred to:

Whereas, The Delegates of the American Medical Association at the AMA meeting in Philadelphia voted for the AMA to support the reintroduction of H.R. 6222 legislation; and

Whereas, According to the *Wall Street Journal* this bill is the second most expensive National Health Bill, exceeded only by the Kennedy-Gorman Bill. Cost estimates range from about 40 billion to almost 200 billion dollars a year; and

Whereas, Employer would be "required to make available and contribute towards the cost of Comprehensive Health Care for their employees and their families"; and

Whereas, Recent studies by the Rand Corporation at Tufts Medical College have proven that an employer-employee compulsory (de facto) taxing mechanism to purchase National Universal Comprehensive Health Insurance would require \$1,000.00 per American job in 1977 and \$2,000.00 per job by 1980; and

Whereas, Such a bill as H.R. 6222 (or its like) if enacted by Congress would eventually result in socialized medicine, inferior medical care, overwhelming inflation, and possible destruction of constitutional freedom of all patients and physicians alike; now, therefore, be it

Resolved, That the Indiana State Medical Association House of Delegates instruct the American Medical Association to:

1. Withdraw its support of National Health Insurance.
2. Launch an immediate education campaign to educate all the American citizen concerning the evils of National Health Insurance—under whatever name; and be it further

Resolved, That the Indiana State Medical Association send a copy of this Resolution, if adopted, to all the State Medical Associations throughout the country and the State Academy of Family Practice Associations throughout the country.

Resolution No. 77-7

Introduced by: Huntington County Medical Society

Subject: PSRO REPEAL
Referred to:

Whereas, The PSRO legislation was introduced and enacted primarily as a "cost controls" mechanism; and

Whereas, On Feb. 12, 1977, as reported in *Medical Economics* by Dr. Charles McSherry, head of the UR Committee at New York Hospital-Cornell Medical Center, that in reviewing 9500 charts, the average cost per ONE case found of overutilization was \$34,267, thereby revealing its counter-results; and

Whereas, PSRO "regulations" have already inflicted irrevocable, destructive, damaging results on Hospital-Board Members-Doctors-Patients Relationship; now, therefore, be it

Resolved, That the Indiana State Medical Association petition Congress to repeal PSRO; and, be it further

Resolved, That the Indiana State Medical Association send a copy of this resolution, if adopted, to all the State Medical Associations throughout the country.

Resolution No. 77-8

Introduced by: Huntington County Medical Society

Subject: TO PREVENT FINANCIAL AMA SUPPORT FOR DR. QUENTIN YOUNG

Referred to:

Whereas, The American Medical Association Board of Trustees has resolved to offer \$15,000.00 in defense of Quentin Young, M.D.; and

Whereas, The following observations, among others, are reported about Quentin Young, M.D.,

1. He was one of the founders and chairman of the "Medical Committee for Human Rights" which in part tried to spread the notion that "most doctors, especially those who were members of the AMA, were unconcerned about human rights."
2. His MCHR Organization paid for a full page ad in the *New York Times*, in 1968, that in part called for Compulsory Political Medicine.
3. The MCHR claimed credit for the Student Health Organization, an organization which "shouted for a North Vietnam victory," etc.
4. Is reported to have been a "sympathizer of the lawless communist dictatorship of Ho Chi Minh."
5. Is reported to be "one of Private Medicine's dedicated enemies."
6. Is reported to have appeared before the House Committee on un-American Activities, October 3rd and 4th, 1968, during the course of hearings on "Subversive involvement in disruption of the 1968

Democratic Party National Convention," and "when asked if he were a communist, he pleaded the FIRST, but not the FIFTH Amendment;" now therefore be it

Resolved, That the House of Delegates of the Indiana State Medical Association request the American Medical Association Board of Trustees to revoke forthwith the financial support offered to Quentin Young, M.D.; and be it further

Resolved, That the Indiana State Medical Association House of Delegates instruct ISMA to send a copy of this resolution, if adopted, to all the State Medical Associations in the U.S.A.

Resolution No. 77-9

Introduced by: Twelfth District Medical Association

Subject: LIMITATION ON HOLDING MAJOR OFFICES

Referred to:

Whereas, The strength of any organization depends on the broad base of able, willing workers and the concentration of decision making in too few individuals tends to limit new ideas and discourage many interested members; and

Whereas, The ISMA in recent years has seen a relative round-robin of major policy decision-making offices within a limited number of individuals; now, therefore, be it

Resolved, That the offices of president-elect, president, speaker of the House, vice-speaker of the House, AMA delegates, AMA alternate delegates, and Board of Trustee members be classified as major offices; and be it further

Resolved, That any individual may not hold more than one major position during a given term and he or she must resign from a major office if they attain a second; and be it further

Resolved, That the ISMA as a general policy encourage appointments that provide as broad a base as possible for its own and state appointed positions.

Resolution No. 77-10

Introduced by: Twelfth District Medical Association

Subject: PRIVILEGE OF DISCUSSION AT REFERENCE COMMITTEES

Referred to:

Whereas, The Reference Committees of the Indiana State Medical Association are the only true forum for each individual ISMA member, and the committees represent the democratic base of the organization; and

Whereas, The Reference Committees have been attended, even monopolized, by paid staff members of insurance com-

panies or special interest groups; now, therefore, be it

Resolved, That only ISMA members have the privilege of discussion at Reference Committee sessions; and, be it further

Resolved, That non-ISMA members may present technical or reference material only with the approval of the Reference Committee which needs that information.

Resolution No. 77-11

Introduced by: Twelfth District Medical Association
Subject: EQUALIZATION OF MEDICAL CARE REIMBURSEMENT

Referred to:

Whereas, The cost of health care has increased dramatically in recent years and many segments of society and government are demanding more efficient delivery of care; and

Whereas, Hospital delivery of medical care has enjoyed special status with the insurance industry so that procedures done in the hospital by private or hospital employed physicians have been reimbursed at a rate above and beyond supplies, overhead, and labor costs; and

Whereas, Many surgical procedures, first aid treatments, and diagnostic procedures can be performed as an outpatient or office procedure and the reimbursement for these have usually been less than if they were hospital based and have rarely included physician overhead cost; now, therefore, be it

Resolved, That the ISMA support changes in the traditional hospital-insurance carrier relationship in order to equitably reduce health care cost; and be it further

Resolved, that the ISMA Board of Trustees should through the appropriate commission or commissions elicit the public's support for modifying existing regulation of the insurance industry to insure such changes.

Resolution No. 77-12

Introduced by: Board of Trustees, St. Joseph County Medical Society
Subject: ASSOCIATION OF AMERICAN MEDICAL ASSISTANTS, INC., INDIANA SOCIETY

Referred to:

Whereas, AAMA, INC., and its affiliated state and local chapters are comprised of employees of actively practicing physicians; and

Whereas, The purpose of the members of this organization is to serve the physician and the patient by furthering their

education in the allied health field; and
Whereas, Their goals are established as truthfulness, helpfulness, integrity, sincerity and loyalty to the allied health field, physician and community; now, therefore, be it

Resolved, That physicians support the concepts and goals of AAMA, INC., and urge their employees to join and actively participate in this organization; and be it further

Resolved, That each district trustee be the ISMA representative to any local or state chapter in his district and to attend any meeting or be an advisor for such chapters if so requested by AAMA, INC.

Resolution No. 77-13

Introduced by: Board of Trustees, St. Joseph County Medical Society
Subject: TRAVEL AND HOUSING ALLOWANCE FOR COUNTY MEDICAL EXECUTIVES

Referred to:

Whereas, Some counties in certain instances have been forced to hire Medical Executives to manage the county medical society program at considerable expense to each physician; and

Whereas, The ISMA has requested that such Executives attend meetings in various parts of the state to establish an interchange of information to benefit members of the state and county societies; and

Whereas, This type of communication benefits the ISMA and its physician members; and

Whereas, These meetings partially alleviate the necessity of field representatives and thus a significant savings in manpower and associated travel expenses, and

Whereas, Travel and housing allowance is paid to physician members attending ISMA committee and Board meetings; now, therefore, be it

Resolved, That any professional County Medical Society Executive be reimbursed by ISMA for travel and housing expenses incurred during attendance at any meeting called by the ISMA other than the annual meeting and specifically for such Medical Executives.
FISCAL NOTE—\$1200.00

Resolution No. 77-14

Introduced by: Seventh District Medical Society
Subject: COMMISSION REPRESENTATION

Referred to:

Whereas, In 1968 the House of Delegates amended the Constitution and By-

Laws of this Association to provide the addition of a Trustee and an Alternate Trustee, representation of Seventh District Medical Society members consistent with the District's relative size; and

Whereas, The Seventh District Medical Society membership continues to represent more than twenty percent of the total membership of this Association; and

Whereas, The Commissions of this Association are designed to provide member input to the deliberations of the Association; and

Whereas, The Constitution and By-Laws restrict the participation of Seventh District members as Presidential appointees to Commissions of the Association, thereby creating a distinct disparity in representation, similar to that which existed on the Board of Trustees prior to 1968; therefore be it

Resolved, That the By-Laws of the Indiana State Medical Association be amended by striking the first sentence of Section 3, Chapter IX, and inserting two sentences as follows: The President shall appoint one Commission member for each 600 active members or major fraction thereof but in any event each District shall have one member on each Commission. Two additional members may be appointed at large without regard for District. Also amend by deletion of the word "five" from the fourth sentence, Section 3, Chapter IX.

Resolution No. 77-15

Introduced by: Marion County Medical Society
Subject: PROVIDING COPIES OF PATIENTS' HOSPITAL BILLS TO PHYSICIANS

Referred to:

Whereas, The percentage of the Gross National Product used for health care is rising; and

Whereas, Physician fees are but a small percentage of this total; and

Whereas, Legislators and the public often tend to blame the rising costs totally on the physician; and

Whereas, Cost containment without sacrificing quality of care or freedom is necessary for the survival of the present pluralistic medical care delivery system; and

Whereas, Physicians order most of the care given to the hospitalized patient; therefore be it

Resolved, That the Indiana State Medical Association work with the Indiana Hospital Association and the medical staff of each hospital in an effort to provide each physician with a hospital bill of at least one of his admitted patients per month, the sample bill to be chosen on a random basis.

Resolution No. 77-16

Introduced by: Marion County Medical Society

Subject: CHILD HEALTH CARE

Referred to:

Whereas, It is a goal of both the public and the Indiana State Medical Association that each individual within the country should have a personal physician who is the focus of coordinating all medical and medically related services for that individual; and

Whereas, In many areas of the country where there are adequate numbers of primary physicians, school districts are pursuing a multitude of disjointed organ-related screening programs; therefore be it

Resolved, That in areas not designated as underserved by the Department of Health, Education, and Welfare, the Indiana State Medical Association encourage local medical societies to oppose mass screenings of school children in fragmented organ system screening programs; and be it further

Resolved, That the Indiana State Medical Association encourage local societies to develop with the schools methods of referral so that each child can have a physician to carry out necessary periodic evaluations of the child as a whole, rather than have the child's care involved in fragmented, disjointed programs.

Resolution No. 77-17

Introduced by: Marion County Medical Society

Subject: MEDICAL COST

Referred to:

Whereas, The cost of medical care has risen rapidly over the past decade, in part due to inflation, part due to new technologies, and in part due to increased utilization; and

Whereas, The actions of physicians play a well-defined role in determining many of these costs; and

Whereas, A well-defined research of the factors affecting the cost of health care are not widely known nor available; and

Whereas, Such research might aid medicine in addressing causes of rising medical costs and to refute the simplistic explanation of rising medical costs offered by medicine's detractors; therefore be it

Resolved, That the Indiana State Medical Association encourage implementation, distribution, publication, and broadcast of research, studies, and reports which address the complex combination of resources and their utilization which effect rises in cost of medical care.

Resolution No. 77-18

Introduced by: Marion County Medical Society

Subject: MATERNAL AND CHILD HEALTH CARE LEGISLATION

Referred to:

Whereas, The Maternal and Child Health Care Act (HR 1702) and its companion bill, the National Health Insurance for Mothers and Children Act (S 370), advocate an entirely new system of health care for women and children of this country; and

Whereas, This legislation would by economic coercion force a substantial portion of these people to give up a system of medical care which they prefer; and

Whereas, This legislation encompasses fiscal strategies that would threaten the economic viability of the country; and

Whereas, This bill represents the first step on the road to total federalization of medical services; therefore be it

Resolved, That the Indiana State Medical Association vigorously oppose the Maternal and Child Health Care Act (HR 1702) and the National Health Insurance for Mothers and Children Act (S 370), encourage all of its components to seek support for this position with their individual legislators, and seek the assistance of other organized segments of the population in this opposition.

Resolution No. 77-19

Introduced by: Marion County Medical Society

Subject: OPPOSITION TO HOSPITAL COST CONTAINMENT ACT OF 1977

Referred to:

Whereas, The Hospital Cost Containment Act of 1977, which was introduced April 25, is designed to contain hospital costs and does not improve patient care services; and

Whereas, The increase in hospital costs can be directly attributed to increases in the minimum wage, hospital and professional liability insurance premiums, and the intensity of patient care in addition to the impact of a highly inflationary economy during the past decade; and

Whereas, Little federal government recognition or support has been given to the widespread cost containment activities promoted by hospitals which include shared medical, management, and supportive services, and

Whereas, The cost of the administration through a burgeoning bureaucracy of this proposal will negate the Act's projected savings; and

Whereas, The provisions of the legislation are patently discriminatory toward voluntary, nonprofit hospitals and will have the effect of converting privately owned and charitable hospitals into public utilities; therefore be it

Resolved, That the Hospital Cost Containment Act of 1977 is discriminatory and selective and is in effect the enactment of wage and price controls which will result in the rationing of health care to the people by either bankrupting hospitals or forcing them to curtail the quality and quantity of services; and be it further

Resolved, That the Indiana State Medical Association oppose this legislation.

Resolution No. 77-20

Introduced by: Marion County Medical Society

Subject: VOLUNTARY CONTINUING MEDICAL EDUCATION FOR ISMA MEMBERSHIP

Referred to:

Whereas, In its scientific component the medical profession functions within the most dynamic body of knowledge; and

Whereas, The appellation "professional" implies continued acquisition of knowledge relevant to the services performed; and

Whereas, The Indiana State Medical Association is recognized as the professional association of physicians in Indiana; therefore be it

Resolved, That the Indiana State Medical Association express its dedication to the continued acquisition of knowledge on the part of physicians by supporting a system of voluntary continuing medical education as opposed to a mandatory system of continuing medical education.

Resolution No. 77-21

Introduced by: Marion County Medical Society

Subject: HEALTH PROFESSIONS CONFIDENTIALITY

Referred to:

Whereas, Privacy is supposedly the one remaining impenetrable castle of an individual; and

Whereas, The United States Government has officially passed legislation protecting confidentiality and

Whereas, The use of computer enables us to forever store any data obtained about any individual and man has never devised a foolproof system to protect any information; and

Whereas, The Health Professions Education Assistance Act of 1976 (PL 94-484) obviously invades the privacy of all

Continued on page 787

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THE CRACKUP, 1936



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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information

ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdose.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

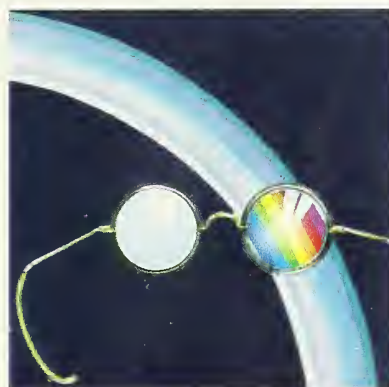
Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response.

Usual optimum daily dosage is 75 mg to 150 mg per day, not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg and 50 mg capsules in bottles of 100 and 1000.

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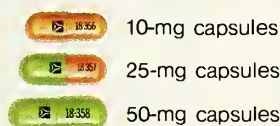


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physicians and dentists and may be extended later to other health professions personnel through the following provision:

"Sec. 708. (a) The Secretary shall establish a program including an uniform health professions data reporting system, to collect, compile, and analyze data respecting all physicians and dentists in the United States and its territories and possessions. The Secretary is authorized to expand the program to include, whenever he determines it necessary, the collection, compilation and analysis of data respecting pharmacists, optometrists, podiatrists, veterinarians, public health personnel, audiologists, speech pathologists, technologists, and any other health personnel in states designated by the Secretary to be included in the program. Such data shall include data respecting the training, licensure status (including permanent, temporary, partial, limited, or institutional), place or places of practice, professional specialty, practice characteristics, place and date of birth, sex, and socioeconomic background of health professions personnel and such other demographic information regarding health professions personnel as the Secretary may require."

therefore be it

Resolved, That the House of Delegates of the Indiana State Medical Association ask the elected representatives in Congress to seek alteration of Section 708 of PL 94-484, the Health Professions Educational Assistance Act of 1976, which singles out physicians and dentists as one specific group for invasion of privacy.

Resolution No. 77-22

Introduced by: Marion County Medical Society

Subject: OPPOSITION TO MANDATED MEDICAL SCHOOL ADMISSIONS

Referred to:

Whereas, The Health Professions Educational Assistance Act of 1976 (PL 94-484) contains as a requirement for any school of medicine to receive capitation grant support for its students, that the school must accept for advanced placement a student quota established by the Secretary of HEW for those U.S. citizens in foreign medical schools who have successfully completed at least two years in such schools and who have passed Part I of the National Boards without consideration of any other academic requirements for admission; and

Whereas, This provisions constitutes a precedent-setting direct Federal intervention in the selection for admissions process of schools of medicine and be-

comes, therefore, an historic intrusion on the academic freedom and independence of universities; and

Whereas, The academic freedom and independence of our society's universities and medical schools are fundamental to advancement in a free society; and

Whereas, The Health Professions Educational Assistance Act of 1976 as enacted will also punish the students in those schools of medicine which do not comply with the above requirement on grounds of academic freedom by denying students enrolled at such medical schools access to the new program of Federally Insured Health Professions loans for their education; and

Whereas, The net effect of this action for such schools who decline to participate will be to deny equal access to medical education to all socioeconomic groups in our Society; therefore be it

Resolved, That since the Health Professions Educational Assistance Act of 1976 (PL 94 484) intrudes on academic freedom and discriminates against students in the United States two-year medical schools in favor of U.S. citizens transferring from foreign medical schools by requiring the U.S. schools to give preference to these transferees as a condition for receiving capitation grants, the Indiana State Medical Association should seek early amendments of the law to either:

1. delete the admissions requirement giving preference to U.S. citizens transferring from foreign medical schools,
2. convert the provision in question to a special project program to which each school could apply and comply as it saw fit, or
3. as a minimum, separate participation in the new Federally insured health professions student loan program from a school's compliance with these capitation requirements.

and be it further

Resolved, That the Indiana State Medical Association strongly support the Indiana University School of Medicine in its opposition to the restrictive aspects of PL 94-484 before the public and the Indiana General Assembly who must guarantee the financial support of the School necessary to oppose this law.

Resolution No. 77-23

Introduced by: Marion County Medical Society

Subject: UNETHICAL TO USE LAETRILE

Referred to:

Whereas, The Principles of Medical Ethics of the American Medical Association provides "that a physician should not use unscientific methods of treatment nor should he voluntarily associate

with anyone who does. It is wrong to engage in or aid and abet in treatment which has no scientific basis and is dangerous, is calculated to deceive the patient by giving him false hope, or which may cause the patient to delay in seeking proper care until his condition becomes irreversible"; and

Whereas, The use of laetrile as a prophylactic to carcinoma and as a carcinoma therapy has no proven scientific merit; and

Whereas, Proponents of laetrile have suggested its use to provide hope to cancer patients without regard to efficacy; therefore be it

Resolved, That the Indiana State Medical Association register its opposition to the involvement of its members in programs which utilize laetrile; and be it further

Resolved, That this Association notify its membership of this action and the cited Principle of Medical Ethics.

Resolution No. 77-24

Introduced by: Marion County Medical Society

Subject: ENDORSEMENT OF A M A GUIDELINES FOR COMPREHENSIVE HEALTH INSURANCE PROPOSALS

Referred to:

Whereas, The American Medical Association has approved guidelines for evaluating the various legislative proposals for Comprehensive Health Insurance; and

Whereas, The American Medical Association is on record in support of sound principles—they include:

Comprehensive coverage for all—both basic and catastrophic benefits,
Uniform benefit coverage for all persons,
Continuation of employment-based insurance funded in the private sector; federal participation should be limited essentially to assisting the poor and low-income individuals in paying health insurance premiums,
Primary administration in the private sector through the use of health insurance with minimum federal administration,
Coverage by private insurers on a risk and underwriting basis,
Freedom of choice by the patient and the physician,
Preservation of the integrity of the physician/patient relationship,
Utilization of pluralistic modes of health care delivery, allowing for further development through innovation and experimentation,
No financing or administration through the Social Security System,

Continuation of present state responsibility for licensure and certification of health manpower; and

Whereas, Senator John Tower has stated that "the most viable means of avoiding the Kennedy-Corman version of socialized medicine is to oppose it with more reasonable alternatives;" this legislative approach to influencing Comprehensive Health Insurance proposals is shared by many in Congress; therefore be it

Resolved, That the House of Delegates of the Indiana State Medical Association endorse the AMA's sound guiding principles for evaluating proposals for Comprehensive Health Insurance; and be it further

Resolved, That the House of Delegates commend the AMA's active participation in the Comprehensive Health Insurance debate; and be it further

Resolved, That the Indiana State Medical Association commend the AMA for continuing to strive diligently to preserve private medical and health care and its financing by building upon the existing system of private health insurance, with minimum federal involvement.

Resolution No. 77-25

Introduced by: Marion County Medical Society

Subject: ESTABLISHMENT OF SECTION ON NEUROLOGICAL SURGERY

Referred to:

Whereas, Neurosurgical care has become an integral part of medical care delivery system in Indiana and the nation; and

Whereas, The neurosurgeons of Indiana are concerned with the recruitment and retention of qualified neurosurgeons for the citizenry of Indiana; and

Whereas, The American Medical Association, recognizing the need to provide neurosurgical physicians a forum within the Federation, has established a Commission on Neurological Surgery; and

Whereas, The American Medical Association of Neurological Surgeons is an active national organization for neurosurgical physicians; therefore be it

Resolved, That the House of Delegates of the Indiana State Medical Association establish an official Section on Neurological Surgery of this Association.

Resolution No. 77-26

Introduced by: Ad Hoc Committee on the Impaired Physician
Subject: PERMANENT ISMA COMMITTEE ON THE IMPAIRED PHYSICIAN

Referred to:

Whereas, The President of the Indiana State Medical Association determined there was a need for an Impaired Physician Program to recognize, treat and rehabilitate physicians who are impaired by neuropsychiatric illness, physical infirmities or alcohol and other drug dependence; and

Whereas, Because of this need and the fact that the districts are generally aware that the problem does exist and most are in favor of a workable program, the president appointed an ad hoc committee to develop a proposed action plan; now, therefore, be it

Resolved, That the Constitution and Bylaws of the Indiana State Medical Association be changed to include The Impaired Physician Committee as one of the standing committees of the Association; and, be it further

Resolved, That this committee be responsible for developing a program in cooperation with the Medical Licensing Board using the guidelines provided in the Medical Practice Act; and, be it further

Resolved, That this program include, but not be restricted to, an informal and formal referral of impaired physicians, list of treatment and referral resources, county medical society screening committees and an examining committee.

Resolution No. 77-27

Introduced by: Vanderburgh County Medical Society

Subject: PARTICIPATION IN PROFESSIONAL STANDARDS REVIEW

Referred to:

Whereas, The House of Delegates of the Indiana State Medical Association has adopted a position opposing the federal professional standards review program on the basis that it is an unwarranted intrusion into the private practice of medicine; and

Whereas, The PSRO law nevertheless remains in effect; and

Whereas, The law gives physicians an initial opportunity to plan and operate the program in reference to non-medical individuals or groups; and

Whereas, Every PSRO area in Indiana now has a physician organization set up for the purpose of planning and carrying out professional standard review; and

Whereas, These bodies are now turning to the Indiana State Medical Association and to the county medical societies for help with various aspects of their programs; and

Whereas, Professional standards review cannot either protect the patient or avoid infringing on the medical profession un-

less it functions in close harmony with the profession; now, therefore, be it

Resolved, That the Indiana State Medical Association recognize that professional standards review is currently the law of the land; and, be it further

Resolved, That the Indiana State Medical Association recommend that its members take an active part in professional standards review in order to protect the best interests of the patient, and to preserve the professional concerns of medicine; and, be it further

Resolved, That the Indiana State Medical Association's philosophical objection to a government-funded program of professional standards review as an intrusion into the private practice of medicine, remains, and is not mitigated by the fact of physician participation in the PSRO program.

Resolution 77-28

Introduced by: Commission on Medical Services

Subject: PROVIDING ANNUAL REPORTS

Referred to:

Whereas, ISMA health providers could be better informed on medical economic matters concerning patient care; and

Whereas, Members and their dependents should be maximally informed on the utilization patterns of themselves as a group; and

Whereas, ISMA should be knowledgeable about the health of its members; now, therefore be it

Resolved, That ISMA should request that Blue Cross-Blue Shield issue to ISMA members copies of their annual reports, unless members wish not to receive them.

Resolution 77-29

Introduced by: Commission on Medical Services

Subject: DISCLOSURE OF PROFILE FOR PROCEDURES

Referred to:

Whereas, The consumer has difficulty in determining the true cost of the individual's medical care under usual and customary or non-assigned Medicare programs; and

Whereas, Even when physicians discuss the fee prior to service, the consumer cannot always obtain the usual and customary from the carrier; now, therefore be it

Resolved, Private carriers and government intermediaries be required to disclose to patients, on demand, the current profile for procedures contemplated.

Resolution 77-30

Introduced by: Commission on Medical Services
Subject: ELIMINATE REQUIREMENTS FOR DISCUSSION OF FEES
Referred to:

Whereas, Without being a party to the negotiations or contract of the usual and customary policy, physicians are obliged to discuss their fees prior to rendering services or accept the assigned profile value (the remainder to be paid by the patient, they are told); now, therefore be it

Resolved, That, in order to resolve this impasse, legislation (state or federal) or regulations, if possible, be supported by ISMA to eliminate requirements for discussing fees in order to attain differential payments from patients.

FISCAL NOTE: Appropriated from Commission on Legislation budget

Resolution 77-31

Introduced by: Commission on Medical Services
Subject: UTILIZATION OF PHYSICIANS AT MEETINGS
Referred to:

Whereas, Daytime meetings concerning health matters are increasing through the years; and

Whereas, Physician representation is desirable, if not imperative, at many meetings; and

Whereas, currently, staff serves well in a reporting role, but is less effective when entering discussions or stating ISMA policy than an adept M.D. in the same role; now, therefore be it

Resolved, That the ISMA budget for regional and central part-time physicians to be trained and paid for representing ISMA at designated meetings.

FISCAL NOTE: \$100.00 per diem; plus mileage

Resolution 77-32

Introduced by: Commission on Medical Services
Subject: REVIEW AND ADJUSTMENT OF FEE PROFILES
Referred to:

Whereas, Insurance carriers are solely responsible for the data systems operations concerning usual and customary health insurance plans; and

Whereas, The medical profession, particularly ISMA, has had an historical and organized interest in this type of program; and

Whereas, Inflation factors in our economy necessitate frequent revisions of usual and customary profiles in order

to make the program relevant and effective for beneficiaries; now, therefore be it

Resolved, That ISMA meet with appropriate labor and management groups to allow for proper insurance regulations or legislation (if necessary) to assure that fee profiles are reviewed and adjusted at least every six months by insurance companies doing business in Indiana.

Resolution 77-33

Introduced by: Commission on Medical Services
Subject: EMPLOYMENT OF DATA ANALYST
Referred to:

Whereas, Data systems for implementation of private and governmental medical programs are designed without input from organized medicine; and

Whereas, Organized medicine is not adequately informed about or concerned with design or programming of data systems; and

Whereas, Organized medicine does not have the capability of analyzing the performance of ongoing computer programs to ascertain whether they are accurate, efficient and meeting the goals of the program; now, therefore be it

Resolved, That the Indiana State Medical Association devise a job description for a data analyst on a part-time or consulting basis whose services would be available to officers, board, staff and research and development bodies such as commissions and ad hoc committees concerned with non-ISMA data programs concerning the practice of medicine in Indiana, particularly a) Medicaid, b) private usual and customary programs, c) actuarial data concerning utilization of ISMA members' insurance plans, d) Medicare, and e) monitoring of proposed data systems such as Health Consortium, PSRO, HSA, etc.

FISCAL NOTE: \$25,000.00

Resolution 77-34

Introduced by: Commission on Medical Services
Subject: SUBMISSION OF INSURANCE PLANS
Referred to:

Whereas, The Commission on Medical Services has an ongoing interest and responsibility in the area of members' insurance plans; and

Whereas, The commission has not received adequate (or at times any) information concerning experience or proposals; now, therefore be it

Resolved, That all insurance plans for ISMA members be submitted to the Commission on Medical Services at least 90 days prior to effective or renewal dates of the various plans.

Resolution 77-35

Introduced by: Commission on Medical Services
Subject: ESTABLISHMENT OF AN ISMA SELF-ADMINISTERED INSURANCE PLAN
Referred to:

Whereas, Inadequate information concerning members' utilization of ISMA health insurance policies has been available to the study and directive bodies of ISMA; and

Whereas, Medicare is blamed for the high cost of care; and

Whereas, Our carrier's claims are going up for high utilizers of health care, so that some members have more than one plan with our present carrier; now, therefore be it

Resolved, That ISMA attempt to establish an ISMA self-administered plan with our present carrier or any future carrier.

FISCAL NOTE: This plan would be financed by a percentage of the participants' premiums.

Resolution 77-36

Introduced by: Commission on Constitution and Bylaws
Subject: MEDICAL STUDENT COMPONENT SOCIETY
Referred to:

Whereas, In the proposed Bylaws of the Indiana State Medical Association it states, "Student members may be represented in the House of Delegates with the power to vote. They shall be entitled to send one delegate or one alternate." (See Division One—Membership, Section 3—Members by Category - I); and

Whereas, Should this portion of the revised Bylaws be adopted, there has been no system established for the election of the student delegate and/or alternate; and

Whereas, The Commission on Constitution and Bylaws recognizes a need for establishing a formal pattern of election of student representatives to the House of Delegates; now, therefore be it.

Resolved, That the House of Delegates endorse the study and possible formation of a special medical student component society of the Indiana State Medical Association; and be it further

Resolved, That in establishing such a society the appropriate Commission of the Association work in conjunction with representatives of the medical student body to formulate suggested guidelines for the accomplishment of the intent of this resolution, and report back to the 1978 House of Delegates.

Ad Hoc Committee on Arbitration

The Ad Hoc Committee on Arbitration and Negotiation met three times during the year. In addition, much study was done by telephone and mail. The committee members also attended the ISMA-AMA Negotiations Seminar in July.

The practice of medicine today is being overwhelmed by insurance carriers, consumer groups, labor unions and federal and state government agencies. Physicians have never before faced such problems from non-medical third party involvement. Demands from unionized hospital employees will ultimately result in hospitals being forced to restrict services. Third party payers arbitrarily set reimbursement schedules and government agencies arbitrarily establish many unnecessary and restrictive controls. We CAN and we MUST begin to influence these organizations in their actions.

Early in our study, it was readily apparent that, due to labor laws and current FTC rulings, the ISMA could not act as a collective bargaining agent in binding arbitration. The ISMA can, however, collectively negotiate in behalf of members, component societies and specialty societies. As we see it, the private practice of medicine as we know it and want it can survive only with the assistance of skillful negotiations, combined with the application of appropriate economic pressure. We must be prepared to act instead of react to proposals which affect the practice of medicine. Each physician cannot negotiate alone. We must have an organization with the advantage of collective power to assist us. Although it is unclear if the FTC will allow negotiating for payment schedules, most other problem areas are open for negotiations. As a matter of fact, Michigan State Medical Society has a negotiating committee which recently entered into successful negotiation with Blue Shield to effect a change in claim filing forms.

As you know, the AMA has established a Department of Negotiations. Through this department, the AMA is conducting training seminars in the art of negotiating for physicians and executives of component societies. The AMA will also assist members in component organizations in the resolution of their particular problem. This will be done by giving advice and even by appearance of department experts as spokesmen at the negotiating table.

Your committee feels that our Association must study this area more thoroughly. It is equally imperative, however, that we get our feet wet by implementing a program to train our own people in the art of negotiating and begin putting it to use. We, therefore, are

recommending that the ISMA establish a permanent Committee on Negotiating. We feel that this committee should be limited to possibly six to ten members. Membership should be for a period of six years and should be staggered to provide continuity of training and services. We would expect that this committee could eventually provide our own component societies, specialty societies and individual members with services similar to those of the AMA's Department of Negotiations. This committee should take full advantage of all programs of training and assistance offered by the AMA Department of Negotiations. Areas in which the committee could be involved, but not limited to, are third party payers, governmental agencies and labor unions.

We feel that implementation of these recommendations will make ISMA better prepared to serve its members in preserving their professional and economic freedom.

It has been a pleasure to serve the ISMA on this committee and I would like to thank the members who diligently gave their time and effort in this project.

R. WYATT WEAVER, M.D.
Chairman

ROGER ROBISON, M.D.; CHARLES HAMILTON, M.D.; HERBERT KHALOUF, M.D.

Ad Hoc Committee on Improvement of Medical and Health Care in Jails

Inadequate medical care in jails has been a long-standing problem for the criminal justice system in this country. Within the past few years, this problem has been the subject of many legal suits. Generally speaking, judges throughout the country have been finding that prisoners have a constitutional right to adequate medical care. In the words of an Arkansas circuit court judge, "If Arkansas is going to operate a penitentiary system, it is going to have to be a system that is countenanced by the Constitution of the United States."

Recognizing the need for national direction with this problem, the American Medical Association applied to the United States Justice Department Law Enforcement Assistance Administration for a grant to develop health care standards for jails across the country. In 1976 the American Medical Association sub-contracted with the state medical associations in Indiana, Georgia, Maryland, Wisconsin, Michigan and Washington. The project was designed to take three years, with the first year being devoted to development and testing of standards. The second year was designed for implementation and further testing

of standards in select pilot jails. The third year was designed for expansion of the project into non-pilot jails.

The Indiana State Medical Association has been working with the county jails in Lake, Morgan, Owen, Greene, Monroe and Brown counties since 1976. During the 1977 fiscal year, beginning in March 1977, the implementation phase was begun. At the present time, we have received accreditation applications from both the Greene and Marion county jails.

Under the direction of Dwight Schuster, M.D., medical director for the ISMA jail project, ISMA staff is actively working with jail personnel in all seven Indiana pilot jails. It seems likely that all Indiana pilot jails will reach accreditation status by the end of this fiscal year.

The physician community has been receptive to the project, volunteering services and, in one case, medical equipment to a jail.

DWIGHT SCHUSTER, M.D.
Chairman
MICHAEL J. HUNTLEY
Project Director

Ad Hoc Committee on the Impaired Physician

The Ad Hoc Committee on the Impaired Physician met on May 5, June 2, and July 7, 1977, since being appointed by John W. Beeler, M.D., president, ISMA.

A major portion of the Committee's time was devoted to investigating programs started in other states and developing a program for Indiana physicians in cooperation with the Medical Licensing Board. In order to provide better coordination between this Committee and the Medical Licensing Board, Dr. Beeler was requested to expand the committee to include a member of the Medical Licensing Board. This done, and John H. Mader, M.D., was appointed.

An Impaired Physician Survey was developed by the Committee and submitted to Dr. Beeler for approval for distribution to medical societies and other medical groups. The survey was approved and was initially distributed to 60 physicians attending a continuing education session for family practice physicians. The results of the survey, completed by 42 of the physicians, showed that 81% believed there is a significant problem in Indiana related to the impaired physician; 93% felt they didn't have adequate facilities or programs in their area for recognition and rehabilitation of the impaired physician; 43% didn't know where to refer a colleague who was having problems with emotional disturbance, alcohol or drug dependence; 98% felt there is a need for an

organized program; 86% also felt such a program should have some coercive back-up. This survey has recently been sent to presidents of county medical societies and hospital staffs, and will be presented to the state psychiatric society for its information and feedback. In addition, the psychiatric society will be requested to submit a list of physicians who would be willing to treat impaired physicians.

The Committee believes that the News Flash should carry a small article informing the physicians that a committee has been formed to develop a program of recognition and treatment, and that the Auxiliary be provided with the same information for inclusion in "The Hoo-

sier Doctor's Wife." This has been done.

It was the unanimous opinion of the Committee that a resolution should be written to make this committee a standing committee of the Association and to include both general and specific goals of the Committee. The resolution has been written and will be submitted for approval at the 128th annual convention of the ISMA.

The Committee has requested space at the annual convention for a scientific exhibit which will be called, "The Impaired Physician: A Treatable Problem." The Executive Committee approved the Committee's request to spend \$100 for purchase of the informational packet put out by the Washington State Medical As-

sociation, which will be used in the exhibit.

The Committee has scheduled another meeting for August 11. It is anticipated that the Committee will continue to meet right up to the date of the annual convention, in order to facilitate its plan of action and to work on the exhibit. A supplemental report will be made at the annual convention to the reference committee assigned to hear its resolution.

GERALD P. JOHNSTON, M.D.
Chairman

RICHARD W. CAMPBELL, M.D.;
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Convention Arrangements Committees - 1977

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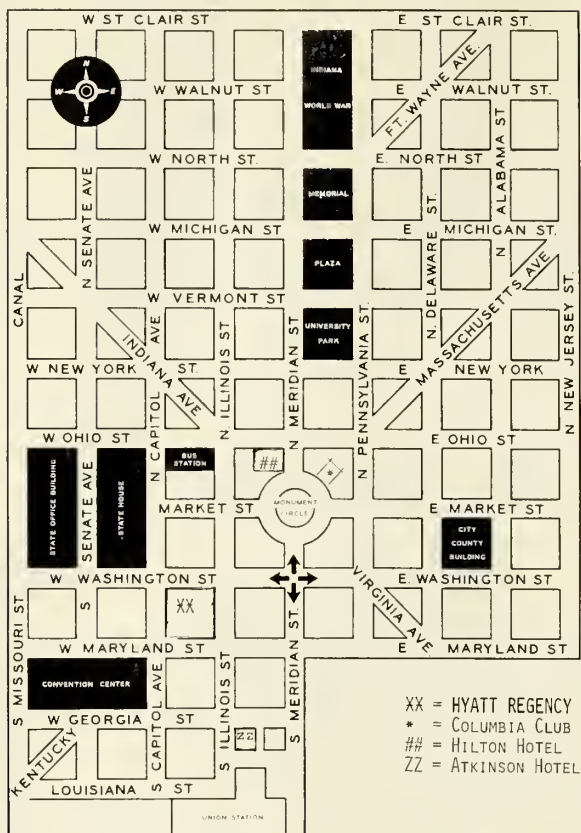
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OCTOBER 1977 • Vol. 70 • No. 10

The JOURNAL

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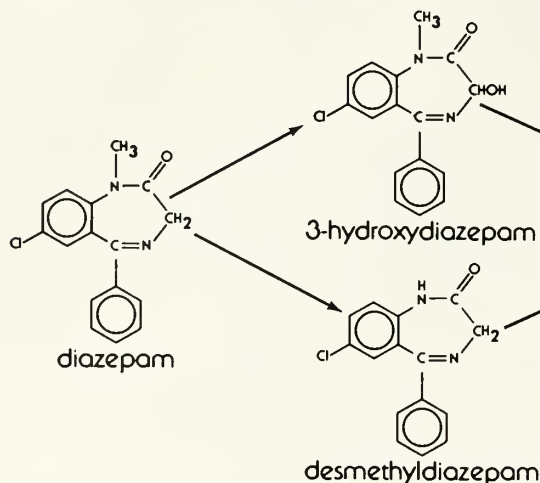
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to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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MEDICAL

MUSEUM NOTES



The Auxiliary of the Indiana State Medical Association has provided consistent and enthusiastic support for the Museum project from its inception. Mrs. Donald White of Indianapolis serves on the Medical History Committee of the Indiana Historical Society and the Indiana State Medical Association and, among other duties, provides the personal contact between the Auxiliary and the Museum. Each year the Auxiliary has made a monetary contribution to the Museum.

The problem was posed as to how the Auxiliary's contributions could be spent most appropriately. To apply these to the general fund, which would be the most practical thing to

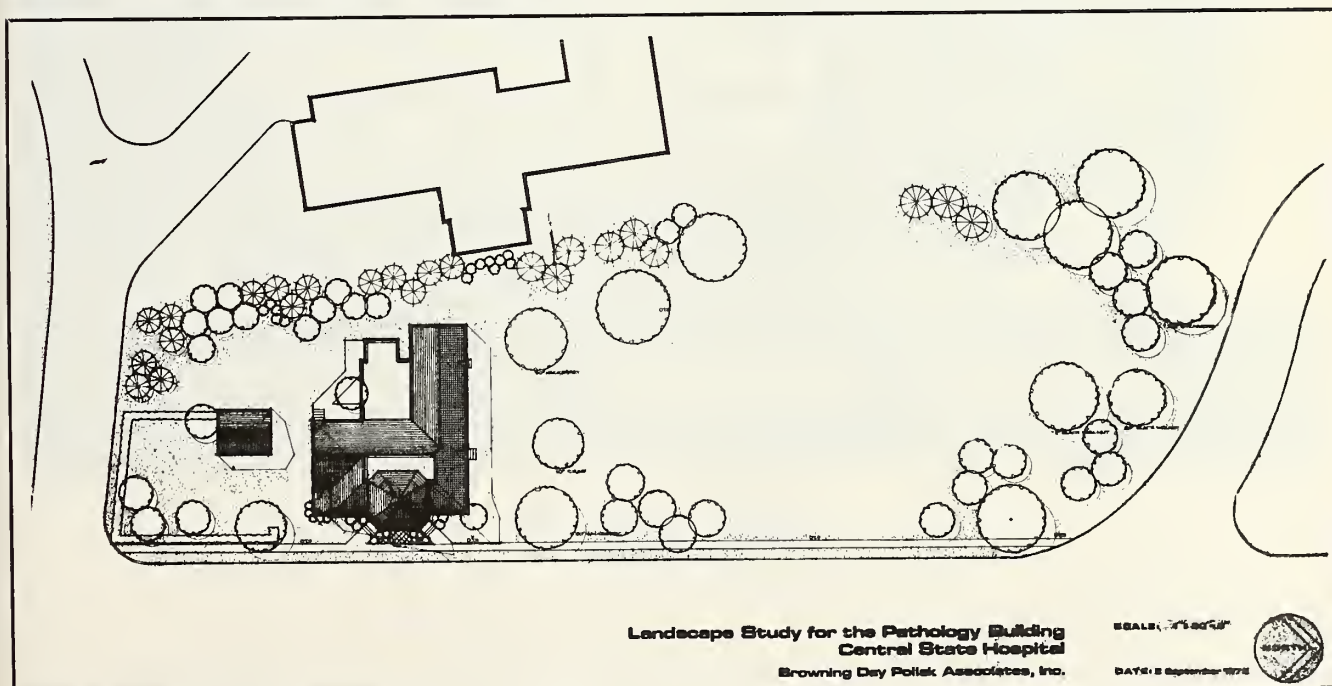
do, would mean that there would be no specific identity of the expenditure with the Auxiliary and this appeared unfortunate. The problem was solved by the timely development of two factors. The first of these was the delivery of the initial draft of a landscaping plan for the Museum (reproduced below) by the firm of Browning Day Pollock Associates. Then, at the time of the final modification of this plan, Mrs. Otis Bowen, who was then president of the Auxiliary, sent a \$250 contribution to the Museum from the Auxiliary, plus an additional \$10, a donation from the president of the Woman's Auxiliary of the Illinois State Medical Association. The latter gift was specifically designated for buying the rose "The Doctor's Wife," this to be planted on the Museum grounds.

While the concept of blooming plants had not been considered in the original plan, the incorporation of a small rose garden dedicated to "The Doctor's Wife" seemed appropriate; and the use of the Auxiliary's contributions on a long-term basis appeared to be a very practical method of achieving the landscaping goal. Both concepts also provided an ideal means of identifying a specific part of the Museum with the Auxiliary.

The Museum has in excess of an acre of ground as part of the National Landmark area. There are two buildings nearby which detract from the appearance of the Museum and the parklike area of the hospital grounds. The landscape plan calls for these buildings to be concealed by pine and other large trees. The complete plan is conceived as an ongoing long-term project, with additions to be made each year.

The rose "The Doctor's Wife" was not available until April 1977. Four plants were set out in a sunny location near the main entrance of the Museum, and these commenced blooming in late May. The first blossom was sent to Mrs. Bowen. The next blossoms were cut and placed on the grave of Mrs. James Wynn, who died in February of this year (see cover and Medical Museum Notes, *JISMA*, 70:1, January 1977). The next blossom the doctor writing this page gave to his own wife. The roses have continued to bloom to the present time, these being clipped and presented to the various doctors' wives who have visited the Museum during the summer months.

CHARLES A. BONSETT, M.D.
6133 E. 54th Place
Indianapolis 46226

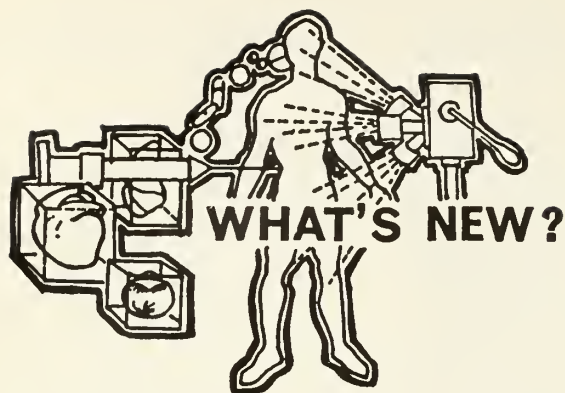


Landscape Study for the Pathology Building
Central State Hospital
Browning Day Pollock Associates, Inc.

SCALE: 1" = 50' 0"

DATE: 2 September 1976





Searle has received FDA approval for marketing of Norpace (disopyramide phosphate), a new drug for treatment of serious and possibly life-threatening heart disorders. Preliminary approval was announced previously. Norpace is used in treatment of ventricular arrhythmias. It has already been introduced in Canada, Germany, Britain and Switzerland.

* * *

Doubleday just released "How to Survive Being Alive," a discussion of stress points and health. Authors are Dr. Donald L. Dudley and Elton Welke, both prolific writers in the medical field. The book examines recent medical research on the relationship between stress and disease. 179 pages—\$6.95.

Smith Kline & French Laboratories announces FDA approval of Togamet (cimetidine) a new drug with promising curative effects on duodenal ulcer disease. Clinical investigation on the drug in the U.S., as well as clinical experience in nine other countries, has been favorable.

* * *

Fisons is introducing its antitussive "cough stopper," Tusscapine chewable tablets, to the occupational health field. Tusscapine has been marketed to the consumer market for the past 18 months. It is a single entity and eliminates problems associated with drug interactions which might occur with other cough depressant products.

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Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

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3.	Claude J. Meyer, Jeffersville	Charles X. McCalla, Paoli	
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6.	Clarence C. Clarkson, Richmond	Hal Rhynearsan, Fortville	Greenfield
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8.	Lowell W. Painter, Winchester	Haward Kach, Winchester	June 7, Muncie
9.	Paul Van Kirk, W. Lafayette	David L. Evans, Lafayette	
10.	James R. Brawn, Valparaiso	Barran M. F. Palmer, Hammond	
11.	William Dannacher, Wabash	Fred Paehler, La Fontaine	
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MONTH IN WASHINGTON

CONGRESS was moving to wrap up work on as much health legislation as possible in preparation for the gathering storm over national health insurance (NHI) in 1978.

The administration was putting strong pressures on senators and representatives to move quickly on President Carter's proposal for a "cap" on allowable hospital revenue increases, insisting that the cost containment plan was a prerequisite for NHI.

Despite the sense of urgency imparted by the Administration, it appeared that jurisdictional problems, a cooling-off by organized labor on the plan, and stiff opposition from hospital and physician groups, would serve to carry the issue over until next year.

The Administration was keeping mum about the form its NHI program will take. About the only certainty at this stage is that the Carter NHI bill will call for implementation in stages to avoid a crushing financial burden on the federal treasury.

In addition to the Hospital Cost plan, Congress in the final weeks of the 1977 session was faced with numerous other health issues.

Some of these bills were fated to remain lodged in Congress until 1978. The only sure bet for passage in 1977 was the appropriations bill which gives HEW several billion dollars

This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

more than President Carter recommended and continues to bar federal Medicaid payments for most abortions.

Other major health bills before Congress included an 18-month delay in the proposed FDA ban on saccharin; amending the renal disease program to encourage self-dialysis and kidney transplants; establishing a separate Department of Health; and freeing federal scholarship stipends from income tax.

The gloomy report by the Congressional Budget Office (CBO) on health spending advised House and Senate Budget Committees that current control efforts "will apparently have little effect on the upward trend in health expenditures . . ."

The report said existing reimbursement, facility and utilization containment programs can be altered by increasing or decreasing the level of regulation. "Changes must be made in hospital reimbursement practices if some immediate impact on hospital expenditures is to occur," the report said.

According to the CBO, "A successful program, whether administered at the state or federal level, would have to break the automatic cost-increase/revenue-increase relationship that is currently enjoyed by individual hospitals. Certificate-of-need programs could be strengthened through increased financial support for the state agencies, more precise federal guidelines, and perhaps limits on capital spending. The cost-effectiveness of PSROs might be improved by restricting utilization review to more questionable medical practices or by emphasizing pre-admission review."

Future growth in the number of physicians could be reduced, particularly by restricting the influx of foreign medical graduates, CBO said, adding:

"Because each additional practicing physician generates expenditures for both hospital and physician care far beyond the level of his net income, strategies to reduce the impact of each physician on total expenditures could be considered. Altering reimbursement schedules and increasing the proportion of physicians in primary care and in prepaid health plans are possible strategies."

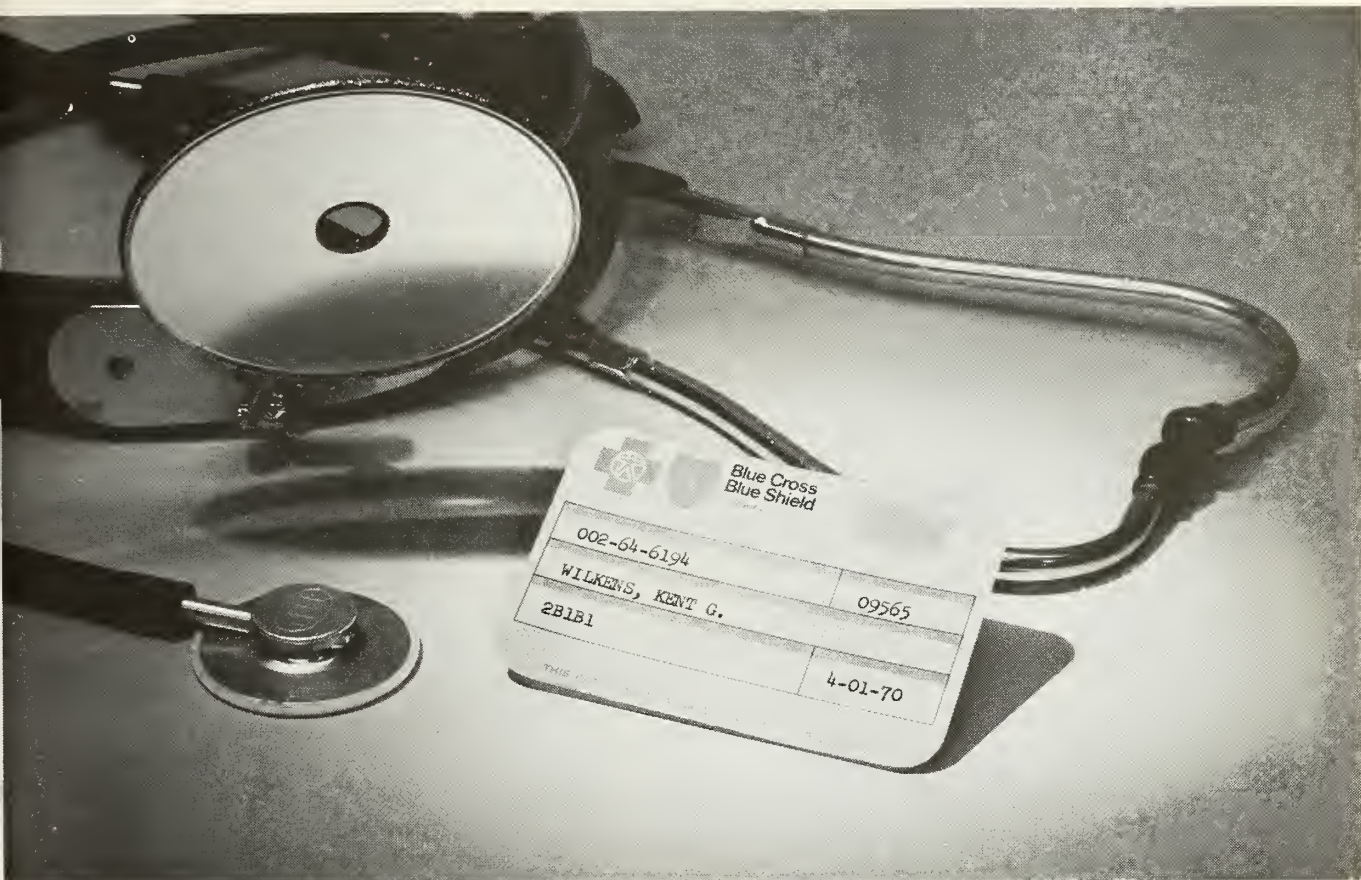
In an 8,800 word critique, the Pharmaceutical Manufacturers Association characterized the Final Report of the HEW Review Panel on New Drug Regulation as a "philosophical endorsement of corrosive regulation" that would create "impediments to the efficiency of the new drug approval process."

Though commending some specific recommendations and comments, including the conclusion that the Food and Drug Administration is neither pro- nor anti-industry, PMA President C. Joseph Stetler says the Panel "consistently slides into the trap of statutory and regulatory solutions."

PMA charged that in perception of the "drug lag," the Panel "manifests further disinterest in the industry's R & D (research) challenges." The critique lists more than a score of important drugs "now accepted as safe and effective in the U.S., which went on the market overseas two or more years ahead of U.S. introduction. The cost of these delays to American patients, in human terms alone, is incalculable." ◀



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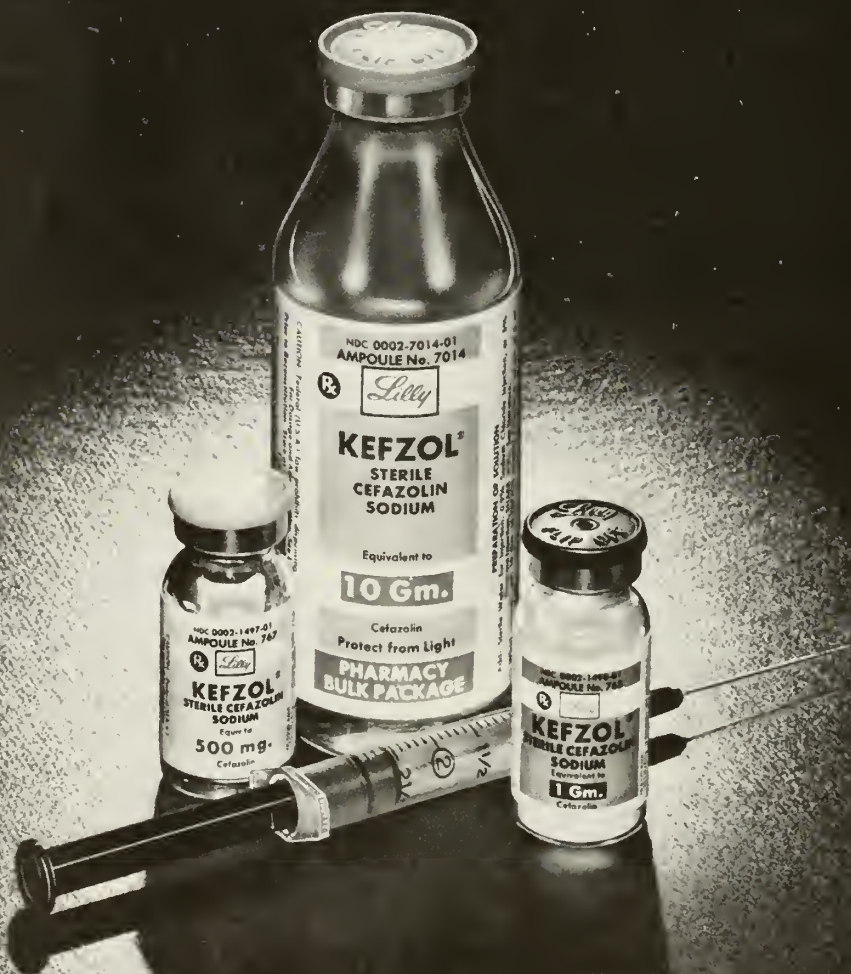
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Type II Hyperbetalipoproteinemia: A Report of Four Severely Affected Children

EDWARD P. ORLOWSKI, M.D.
DONALD A. GIROD, M.D.
Indianapolis

Abstract

FOUR cases of children severely affected with Type II hyperbetalipoproteinemia are presented. Clinical presentations and responses to diet and drug therapy are reviewed. Of special interest is that although all four children have clinical presentations consistent with the rare homozygous form of this disease, three have atypical inheritance patterns. Drug therapy is discussed along with newer forms of treatment. Relevance of the disease to adult coronary artery disease is discussed.

Type II hyperbetalipoproteinemia is a hereditary disorder resulting in elevated serum cholesterol, xanthomas and, most important, early onset of coronary heart disease. Inheritance is thought to be due to an incompletely dominant autosomal gene. Both heterozygous and homozygous forms of the disease are recognized. The heterozygous form occurs in about one in 200 births. The clinical manifestations of xanthomas and premature atherosclerosis usually occur after age 30. Cho-

lesterol levels range from 250 to 500 mg%. The homozygous form is very rare, probably present in one per million population. The homozygous forms develop xanthomas during the first few years of life. Cholesterol levels often exceed 800 mg%. Coronary artery disease develops early in childhood. Death from myocardial infarction usually occurs before the age of 30.

This report concerns four children with clinical presentations consistent with the homozygous form of the

disease. Despite its rarity, the homozygote needs prompt identification and treatment. In addition, it is possible that study of the severely deranged cholesterol physiology of the homozygote may also increase understanding of the less severely affected but more common heterozygote. Of special interest in these four cases is the resistance to drug treatment and observations related to the pattern of inheritance.

Patient 1 was referred at the age of four years. At that time he was noted to have multiple xanthomatous lesions in the gluteal cleft of the buttocks, on the anterior surface of the knees, both popliteal fossae, and Achilles tendons. (Figure 1)

For Patient 1, the initial cholesterol was 870 mg%. Triglycerides were 175 mg%. Lipoprotein electrophoresis showed increased beta-band. Electrocardiogram and chest x-ray were normal.

The father, age 44, had a serum cholesterol level of 313 mg% and triglycerides were 178 mg%. The mother, age 36, had cholesterol and triglyceride levels of 284 mg% and 149 mg% respectively. Both parents had increased beta-bands on lipoprotein electrophoresis. There were no siblings and no other significant family history was available.

Therapy and responses are noted



FIGURE 1. Xanthoma present on Achilles tendon.

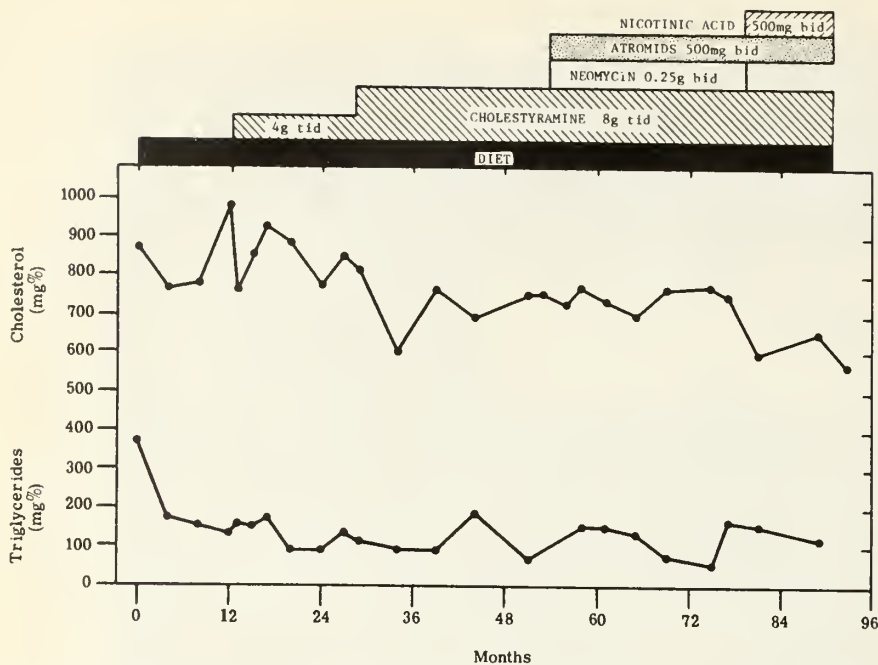


FIGURE 2. Graph of serum cholesterol levels versus time with different forms of therapy for Patient 1.

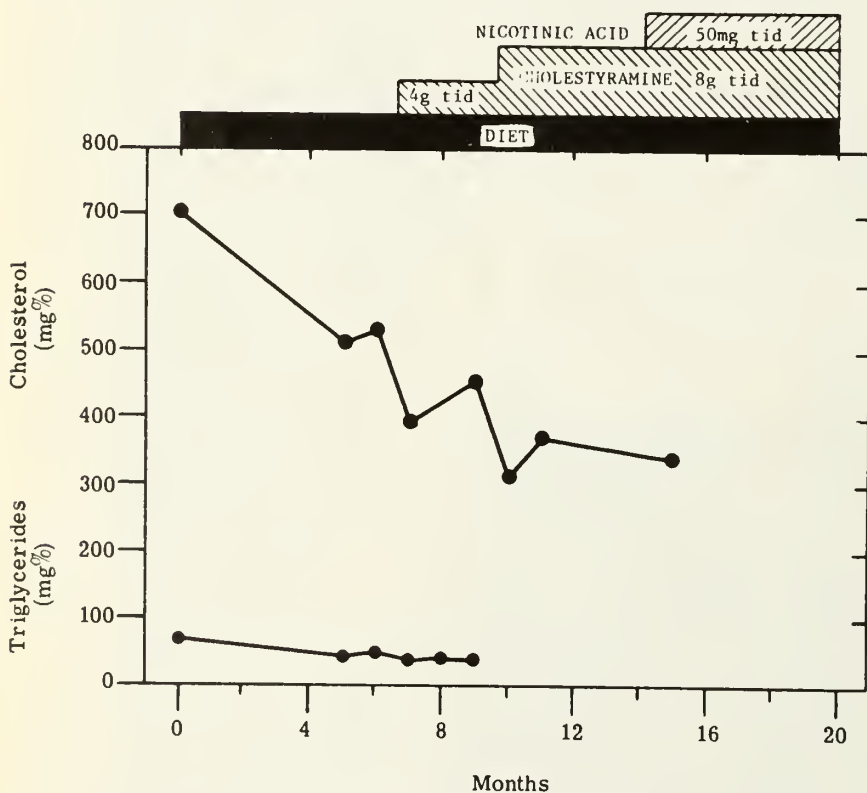


FIGURE 3. Graph of serum cholesterol levels versus time with different forms of therapy for Patient 2.

in Figure 2. The patient was begun on a low cholesterol diet high in polyunsaturated fats (200 mg cho-

lesterol/day). After one year, because of continued high cholesterol levels, cholestyramine, 4 gm t.i.d.

was started. As noted on the graph, an increase in cholestyramine was necessary along with the eventual addition of Atromid-S, neomycin and nicotinic acid. The patient's last therapeutic regimen was Atromid-S 500 mg b.i.d., nicotinic acid 50 mg t.i.d., cholestyramine 8 gm t.i.d. His last cholesterol level on these dosages was 643 mg%.

Patient 2 was first seen at age seven years. At age three he was noted to have nodules present on his elbows and popliteal fossae. Three years later, biopsies proved them to be xanthomas. When seen at this institution physical examination revealed bilateral arcus senilis on the inferior aspect of each limbus. A grade 2/6 systolic murmur was heard at the apex. Xanthomas were noted on elbows, anterior aspect of each knee and each popliteal fossa, and the cleft of the buttocks.

One year before referral, Patient 2 had a cholesterol level of 700 mg%. After one year of dietary therapy his cholesterol level was 510 mg%. Triglycerides were 51 mg%. Lipoprotein electrophoresis revealed an increased beta-band. Electrocardiogram and chest x-ray were normal.

The patient's maternal grandfather died at age 36 of a myocardial infarction. The mother's cholesterol was 340 mg%; triglycerides were 49 mg%. The father, age 26, had a cholesterol level of 184 mg% and triglycerides of 63 mg%. The mother's sister and her son reportedly had normal levels. No further family history was available.

Therapy and responses are shown on Figure 3. Patient 2 was started on a 150 mg/day cholesterol diet, and a polyunsaturated/saturated fat ratio of 2:1. Two months later, because of continued high cholesterol levels, the patient was started on cholestyramine 4 gm t.i.d. The dose of cholestyramine was eventually doubled and nicotinic acid was started at 50 mg t.i.d. The last cholesterol level on this regimen was 340 mg%.

Patient 3 was first noted to have subcutaneous nodules on his Achilles

tendons at age eight. Three years later these were identified as xanthomas, and others were noted on his elbows and extensor tendons of the hands. A heart murmur was also detected.

The initial cholesterol level was 780 mg%. An electrocardiogram showed left ventricular hypertrophy and st-t wave changes. Chest x-ray was normal. Cardiac catheterization revealed mild aortic valvular stenosis and mild aortic insufficiency. There was also a localized supravalvular narrowing. Coronary cineangiograms showed significant filling defects in all major branches. (Figure 5)

The father, age 39, and three siblings had normal cholesterol levels. The mother had a cholesterol level of 360 mg%.

Therapy and responses are noted in Figure 4. Patient 3 was treated with diet and eventually cholestyramine 8 gm t.i.d. and nicotinic acid 100 mg q.i.d. The last cholesterol level on this regimen was 594 mg%.

Patient 4 was an 18-year-old white female. Past medical history was unremarkable except for a history of rheumatic fever with no detectable residual cardiac damage. She was well until three days prior

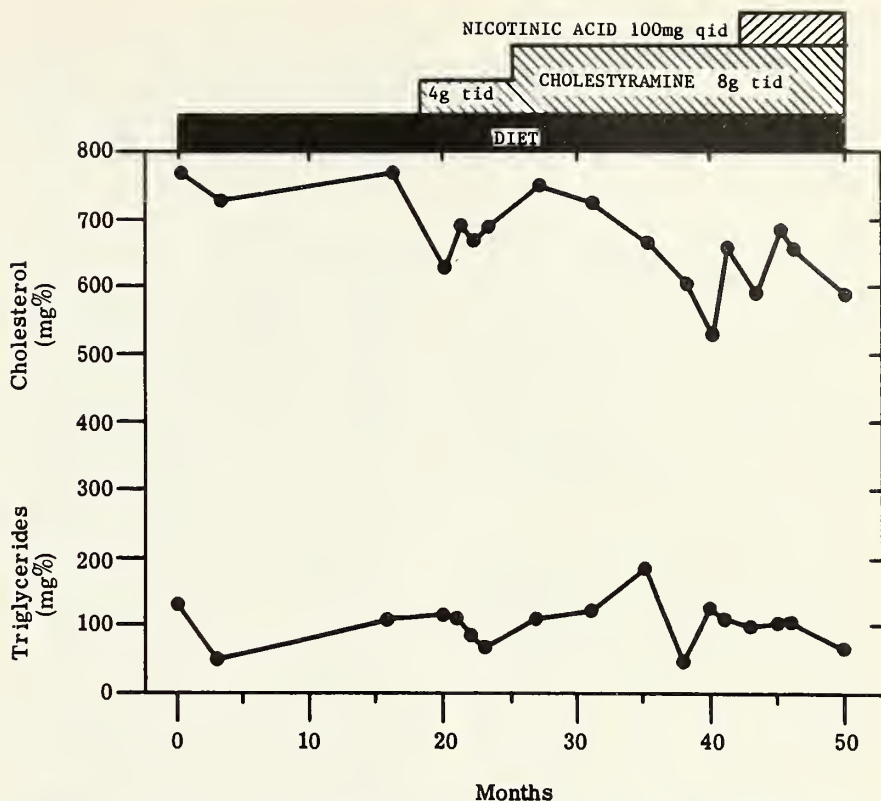


FIGURE 4. Graph of serum cholesterol levels versus time with different forms of therapy for Patient 3.

to her death, when she began having substernal chest pain. Postmortem examination revealed marked generalized atherosclerosis. Severe ar-

teriosclerosis of the coronary arteries was noted with occlusion of the left coronary artery. (Figure 6) There was evidence of an anteroseptal

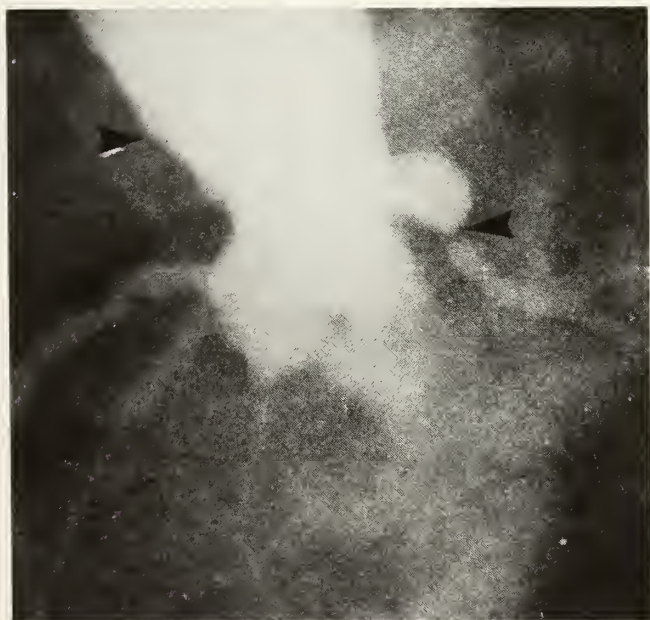


FIGURE 5. Cineangiogram with upper arrow depicting irregularity of ascending aorta from atheromatous plaques. Lower two arrows point out filling defects in coronary arteries. (Patient 3)

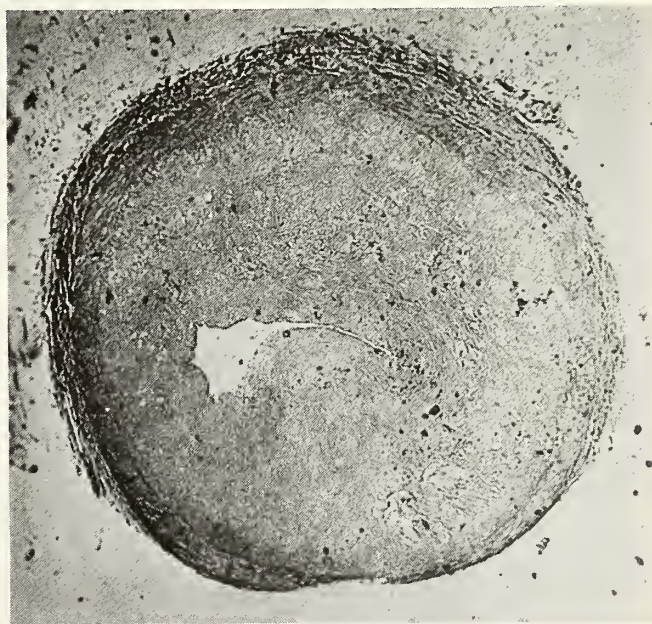


FIGURE 6. Microscopic section of left coronary artery with occlusion from marked atherosclerosis. (Patient 4)

myocardial infarction.

The patient's mother had noted xanthelasmas under her left eye six years previously. On physical examination she also had xanthomas on the extensors of both hands and Achilles tendons. Her cholesterol level was 260 mg% and the triglycerides were 43 mg%.

The father had a cholesterol level of 190 mg% and a triglyceride level of 130 mg%. Two siblings had normal physical exams. Their cholesterol levels were 256 mg% and 243 mg% respectively. Triglycerides were normal in both.

One sibling reduced his original level of 256 mg% to 195 mg% over a four-year period on diet and Atromid-S (1 gm b.i.d.). The second sibling had a reduction from 243 mg% to 226 mg% on diet and Atromid-S (500 mg b.i.d.). The mother's original level of 260 mg% was reduced to only 246 mg% over the same time period on Atromid-S (1 gm b.i.d.).

Discussion

In the past there has been much controversy regarding the different factors distinguishing heterozygotes and homozygotes. Fredrickson has proposed stringent criteria.¹

The heterozygote is defined as having (1) the Type II pattern on lipoprotein electrophoresis and either (2) a first degree relative also with Type II or (3) tendon xanthomas.

The homozygote is defined as one who has (1) the Type II pattern on lipoprotein electrophoresis and (2) Type II in both parents, or, as is usually necessitated by the excessive mortality of such relatives, at least evidence of Type II in both parental lines, and (3) cholesterol concentrations that are roughly twice as great as those in heterozygotes in the same kindred.

Past reports of kindreds with familial hypercholesterolemia have shown the inheritance pattern of this disease to be consistent with an

autosomal dominant gene.^{2,3,4} In addition, Goldstein's model^{5,6} of the cholesterol physiology in this disease lends support to this inheritance pattern and the existence of homozygotes and heterozygotes. In reviewing Patient 1 of this report, Fredrickson's criteria for the homozygous form have been met. Clinical presentation, laboratory values and family history are compatible with the homozygous form. However, Patients 2, 3, and 4 have a similar early onset of severe disease without the criteria of inheritance. Whether these three patients are actually homozygotes or severe heterozygotes, with unknown factors affecting the clinical presentation of the parents or patients, is open to further question and study.

In Patients 1, 2, and 3, (Figures 2, 3, 4) treatment and response are recorded. Dietary restrictions of cholesterol and saturated fats combined with various combinations of cholestyramine, nicotinic acid and Atromid-S have proven to be inadequate forms of therapy. Only one patient (#2) even approached normal serum cholesterol levels, while the other two achieved only mild decreases. Better treatment is needed.

Goldstein's studies^{5,6} have suggested that the synthesis of cholesterol should be the main focus of attention in treatment of this disease. If his model of the expression of the gene on the molecular level is correct, specific inhibitors of cholesterol synthesis would be helpful in treatment. These specific inhibitors are currently being studied.⁵

The homozygous type of familial hypercholesterolemia (type II a phenotype) frequently responds poorly to dietary and drug therapy. Intravenous hyperalimentation,³ plasma exchange, ileal bypass⁸ and, most recently, portocaval shunts³ have been used successfully. Of these, portocaval shunt has been shown to dramatically reverse coronary and aortic atherosclerotic lesions in one

patient⁹ and to substantially reduce cholesterol levels in 10 of 12 others.¹⁰ Portocaval shunt may become the treatment of choice in this lethal disease. The mechanism by which portocaval shunt lowers cholesterol is poorly understood. Aherns¹¹ suggests that careful study of homozygous patients before and after portocaval shunt may elucidate the mechanism by which the cholesterol level falls and may increase the understanding of lipid metabolism in the more common heterozygous and polygenic forms of hyperlipemia.

The few severely affected patients presented here demonstrate that hyperlipidemia and atherosclerosis may occur in childhood and adolescence. More commonly, overt disease is not apparent until after age 30. However, even in these cases the pathologic process probably has begun in childhood and adolescence. Dietary and other habits are established at this time. Coronary atherosclerotic lesions are present in individuals in their twenties, as has been reported in autopsy studies of Vietnam and Korean war casualties.⁷ Screening technics to find children with hyperlipidemia are not yet practical. Determination of serum cholesterol and triglyceride values in children and other close relatives of individuals suffering myocardial infarction before age 50 has been advocated. It is apparent that if significant modification of risk factors related to coronary artery disease is to be achieved efforts must begin in the pediatric age group. ◀

Acknowledgment

The authors are indebted to Drs. Richard Powell, Ira K. Brandt and Roger A. Hurwitz of the Indiana University Medical Center for their assistance.

A copy of the references pertaining to this paper may be obtained by writing to THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

The Case of the Missing Spicebush Twig

HELEN B. BARNES, M.D.
Greenwood

It seems appropriate now and then for the medical profession to look back at the state of the art in yesteryear. The pediatric case to be presented will not so much laud the accomplishments of our profession as it will the great restorative power of Nature, which in this technological age is too often overlooked.

The case history to be related concerns Mrs. Nancy McCoy Hamilton Adams and is quoted directly from a paper "Some Reminiscences of My Childhood Days" written by her when she was almost 82 years old. She was born March 12, 1826, in the Kingston community, Decatur County, east of Greensburg, Indiana.

The narration begins: "Accidents happened of course. I will relate one which seemed very serious for a time as I came near losing an eye. When I was about five years old I fell from a high rail fence on to a clump of spice bushes, and one of the branches ran up one of my nostrils. I pulled out the projecting stick before help reached me. The blood streamed from my nose and mouth, and there was a very sick little girl carried home that day and for several weeks afterwards.

"The opposite eye from the sore nostril was greatly affected, swollen almost to bursting with the lids always closed and every effort to open

them seemed unavailing. The doctor probed in my nose but could find nothing, yet he felt convinced that a piece of the stick had been left in somewhere which caused so much inflammation and found he was correct by fitting the pieces of the stick together, but as no one knew what could be done about it, some weeks passed with but little change when a remarkable circumstance happened.

"A good faithful animal, the mother of a young colt, had been sick for hours with what they called colic, and at bedtime father left her in the dooryard, thinking nothing more could be done for her, but the suffering creature seemingly in hope of relief went round and round the house, until finally she fell against one of the side doors, which burst from its hinges, landed on top of a bed that, providentially, was not occupied, and poor Dolly fell dead on the floor inside the room. I was lying in my mother's arms and with the shock my eye opened which had been so long closed. My mother's heart overflowed with thanksgiving and tears of joy fell on my face and from that time on my eye improved steadily. I was aware that there were grave fears that I would be disabled for life and for some time there was a great difference in my eyes, but I outgrew this to a great extent.

"But the strangest part of this incident remains to be told. About 23 years after the accident occurred, and had been almost forgotten, I was sitting one evening reading aloud to my family, which was rendered difficult by my nose being much stopped up with cold, and I resolved to make an effort to clear it with one good blow, when lo, the identical piece of spice stick loosened from its moorings of so many years, put in its appearance. I felt it come into my nostril and pressed it out. It was in good state of preservation, about one and one-half inches long and only one-half of the stick, the crease for the pith showing plainly on that side and there was considerable bark still on the other side. It was thought it had lodged in the cavity in front of the brain, and I was not aware of the occupant. Doubtless it was better so."

To the reader is left the task of explaining the sudden opening of the closed eyelid and delineating the resting place of the errant spicebush twig for 23 years!

Summary

Case history of an accident that befell a five-year-old child in 1831 and its surprise ending 23 years later, as told by the victim.

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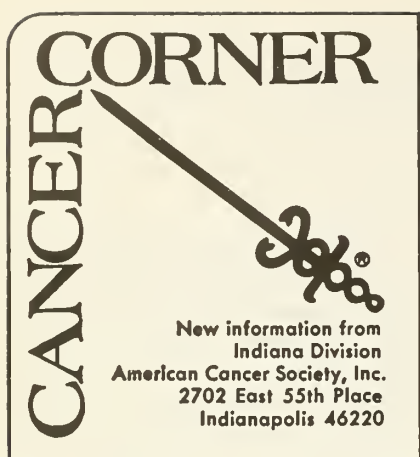
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New Literature

The annual Professional Education Publication, **Cancer Statistics, 1977**, is now available. This publication contains a broad spectrum of information including estimates of cancer incidence based on newly

available data of the National Cancer Institute's Third National Cancer Survey. It is estimated there will be 690,000 new cases and 385,000 deaths from cancer in 1977. Data on incidence, mortality and survival are detailed. Statistical data are presented in tables and charts.

The Last Day of April. This is a poignant story by the mother of a leukemic child. She tells how she and her family were able to cope with the day-to-day disappointments and joys while waiting for the last day of April, when her daughter died. This is a good booklet for leukemic families and individuals working with leukemia patients.

What Is Chemotherapy? This is a pamphlet which explains to the cancer patient: What Is Cancer Chemotherapy? Use of Chemotherapy. Effects of Chemotherapy. How is Chemotherapy Given? Precautions. New and Unproven Drugs. Special Note to Cancer Patients.

Materials are available upon request from the Indiana Division office or from your local ACS Unit.

Laetrile Update

The National American Cancer Society Board of Directors on June 9, 1977, approved the following statement on Laetrile:

1. That, in view of recent developments, the Committee's summary statement expressing the Society's official position on Laetrile, be revised to read as follows: "A review of all reported material available to the American Cancer Society shows that Laetrile is not effective in the prevention or treatment of cancer in human beings.

2. That, since there is a growing public and legislative interest in Laetrile and in its effect and use, and since the Society has a responsibility for informing the medical profession and the public at large on matters concerning cancer, the American Cancer Society reaffirms its support for the protection of the cancer patient through strict adherence to FDA established methods of scientific testing, and, further, that it does

not approve of any exceptions to such methods for any particular substance.

Emotional, Financial Problems of Childhood Cancer

In a series of studies of the emotional and financial problems experienced by families with children who have cancer, the Pediatric Oncology section, University of Kansas Medical Center, has found that 10% of children treated for cancer there had school phobia—a syndrome involving refusal to go to school, somatic complaints and fear of separation from the mother. On the average, these children missed 78 days out of a 180-day school year, significantly higher absenteeism than that of the general school age population.

The researchers also learned that the divorce rate among parents of children with cancer was surprisingly lower than the rate for the general population. Psychological tests indicated that these couples suffered less stress than couples who required marriage counseling, but more stress than parents of hemophiliacs or normal children. Siblings of child cancer patients experienced lower self-esteem than patients, supporting speculation that they need more special attention.

The studies also pinpointed the average hidden, non-medical costs—in addition to the medical costs—to the family having a child under treatment for cancer either at home or in hospital, at \$18/day, or \$537/month. These include extra food costs, lodging in motels and hotels, clothing (which may mean three different-sized wardrobes for a child treated with steroids, which cause enormous weight fluctuations), transportation, babysitting, loss of wages.

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

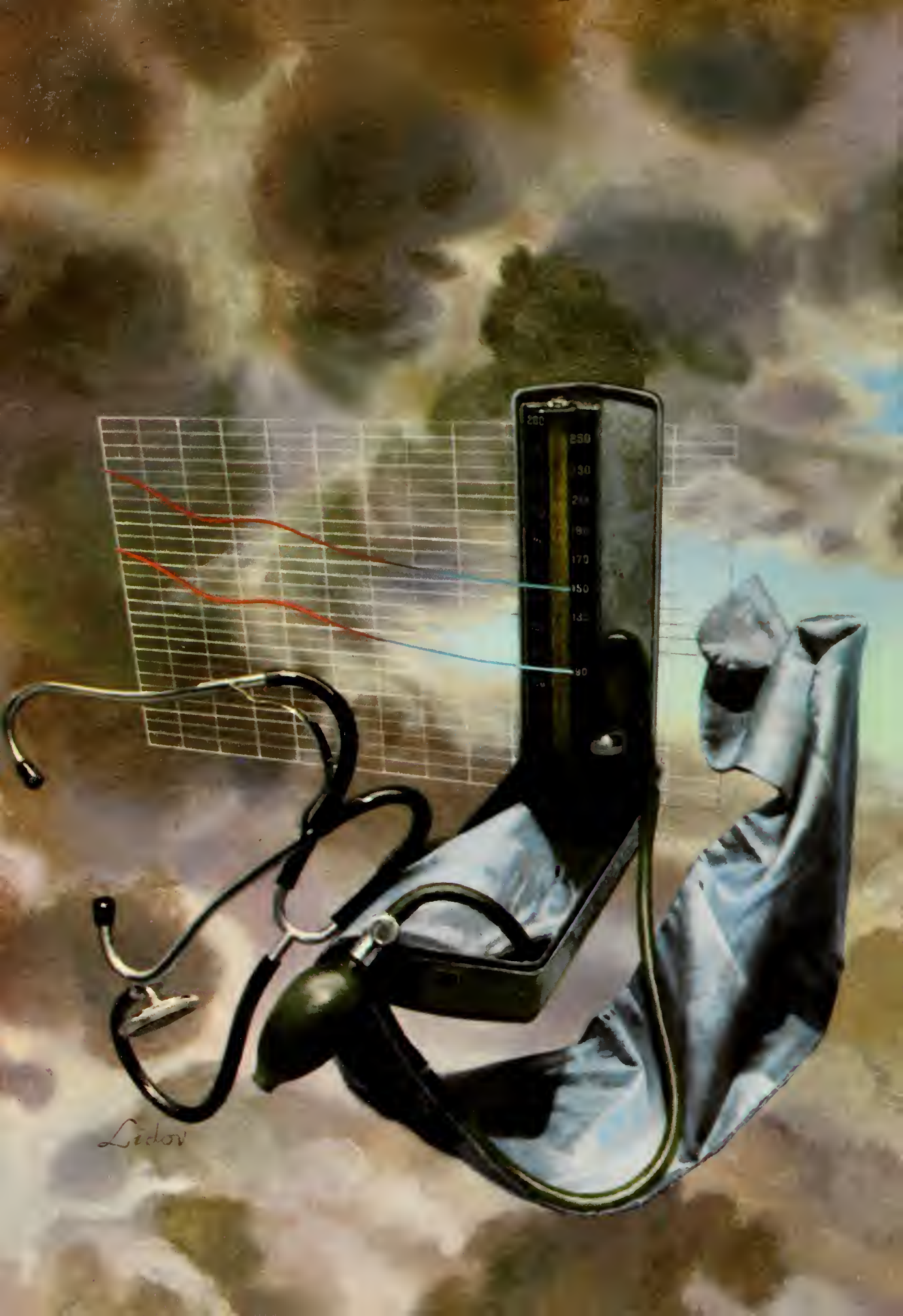
affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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Recommended initial dosage in mild to moderate essential hypertension—2½ to 5 mg once daily

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma, allergy or hypersensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Hyponatremia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed

against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur in edematous patients in hot weather. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyper-

glycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment may be necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References:

1. Dornfeld L, Kane R: Metolazone in essential hypertension. The long-term clinical efficacy of a new diuretic. *Curr Ther Res* 18:527-533, 1975.
2. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Curr Ther Res* 20:745-750, 1976.
3. Data on file: Medical Department, Pennwalt Prescription Products.



Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification
at His Home Without
Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony,
But Both Factions Are

WASHINGTON, Aug. 26, 1920—
struggle for wom-



TRUMAN CLOSES UNITED NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great
Instrument of Peace,'
Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, "we shall betray all of those who have died in order that we might meet here in freedom and safety to create it."

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

Social Security Bill Is Signed Gives Pensions to Aged, Jobless

Roosevelt Approves Message Intended to Benefit 30,
Persons When States Adopt Cooperating Laws—He
the Measure 'Cornerstone' of His Economic Program

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10,
1971—The Senate approved
today, 94 to 0, and sent to

WASHINGTON, Aug. 26.
The Social Security Bill,
a broad program of unemploy-
ment insurance and old age
insurance and counted upon to be-
nefit 20,000,000 persons, became
law today when it was signed by
President Roosevelt in the presence
of those chiefly responsible for
bringing it through Congress.

Mr. Roosevelt called the bill
"the cornerstone of my economic
program which is being put into
effect by the Social Security Act."

the Draft Ends No

WASHINGTON, Jan. 27,
1973—"With the signing of
the peace agreement in
Paris today, and after re-
ceiving a report from the
Secretary of the Army that

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.



THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
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An Approach for the Comprehensive and Efficient Evaluation of Secondary Hypertension

CLARENCE E. GRIM, M.D.
Indianapolis

MOST hypertensives can be successfully treated with anti-hypertensive agents. However, there are occasions when a comprehensive search for curable forms of hypertension is desirable. The following example is a suggested approach in such cases.

Ms. H.B., a 45-year-old woman, is in your office. You have measured her blood pressure on three occasions because she was found to have a blood pressure of 180/120 at the County Heart Association Hypertension Screening Booth. Her blood pressure has consistently been 170/110 in your office. How do you proceed to rule out curable causes of hypertension before you commit her to a lifetime of drug treatment?

History and Physical Examination: First, you must listen carefully to her history and inquire about the duration of hypertension (a sudden onset should alert you to suspect a curable cause). Does she take birth control pills or estrogens? Either of these agents can cause mild or severe hypertension. The most common curable cause of hypertension you will see in your practice will be due to these agents! Does she have episodes of hypertension, headaches, sweating or palpitations that would make you suspect a pheochromocytoma? Does she have a moon-shaped face, central obesity, easy bruising or muscle weakness to suggest Cushing's syndrome? Next, you do a careful physical exam and

look for retinal hemorrhages which, if present, indicate malignant hypertension and demand immediate treatment. Then examine the epigastric area for the presence of a *bruit which has both systolic and diastolic components*. If this is present, then the patient almost surely has renovascular stenosis which is causing the bruits and the hypertension. Finally, measure the pressure in the legs and palpate for a radial-femoral pulse lag. If the pressure is lower in the legs than in the arms or there is a radial-femoral pulse lag, you should suspect a coarctation of the aorta.

Initial Laboratory Evaluation: Before starting therapy, you should obtain a serum potassium (usually low in primary aldosteronism), a blood urea nitrogen and/or creatinine (these will be increased if the high blood pressure is due to parenchymal renal disease) and a urinalysis. A rapid sequence (1, 2, 3, 4, 5, 10 and 15-minute films) hypertensive intravenous pyelogram is also ordered to screen for renovascular hypertension (85% of patients with renovascular hypertension will have EITHER a systolic-

diastolic epigastric bruit OR an abnormal IVP).

The Decision to Treat or to Pursue Further Investigation: At this point you must decide whether to treat the patient or to pursue a more intensive (and expensive) evaluation. Table I lists some of the frequent indications for a comprehensive evaluation. Certainly, if any of the clues to secondary hypertension mentioned above are present, then an evaluation would seem mandatory. If no evidence of secondary hypertension is found, then a trial of therapy should be considered. You should be aware, however, that publications from the Mayo Clinic suggest that patients with renovascular hypertension do better in the long run if their disease process is corrected surgically than if the blood pressure is lowered to acceptable levels with antihypertensive medication. That is, if the patient has renovascular hypertension, her chances of surviving another 10 years are two times greater if she has surgery than if she is treated medically.

The Algorithm

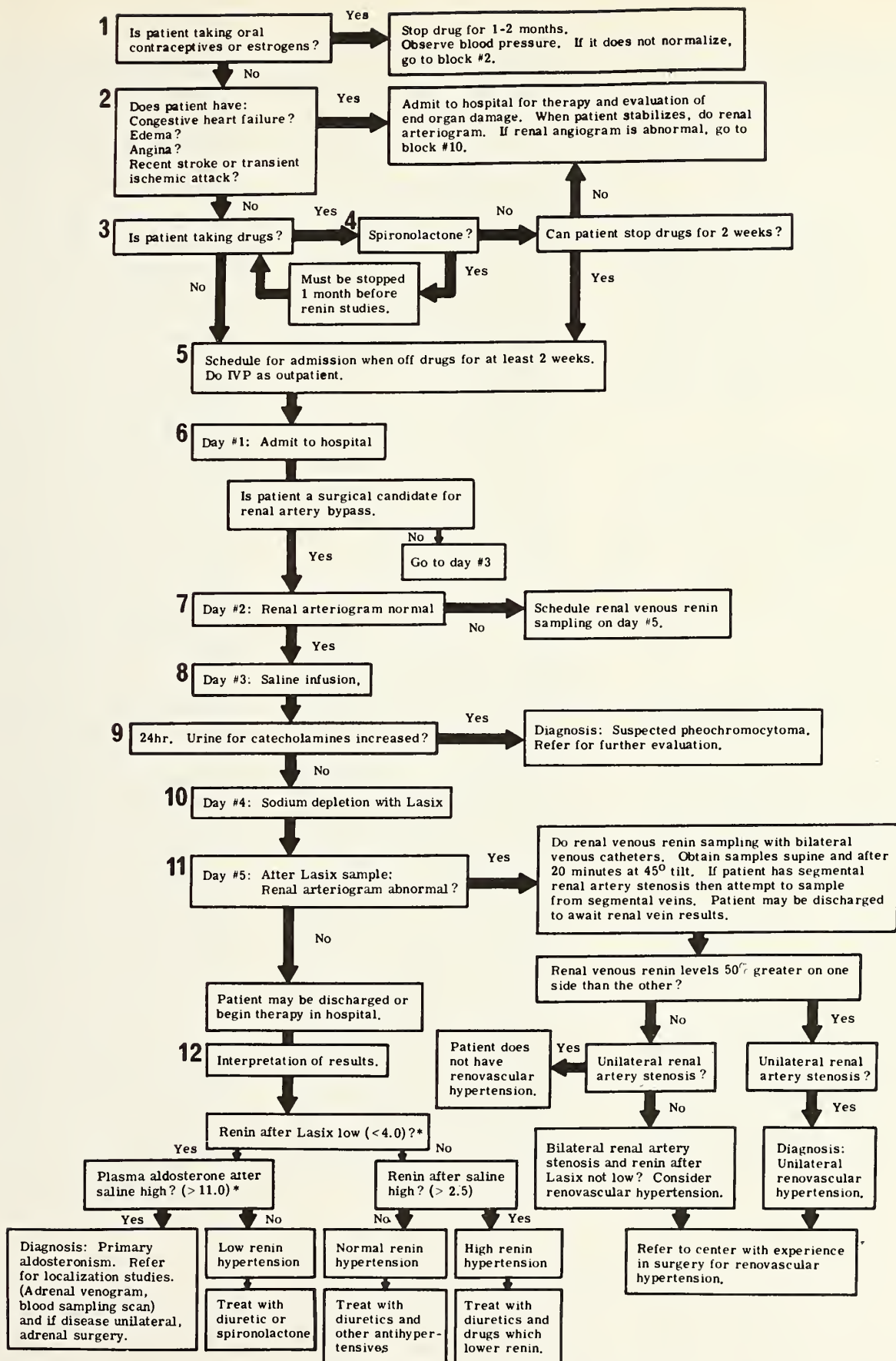
If you decide to pursue further evaluation, the algorithm shown in Figure 1 will allow you to do this in a most efficient manner and require that the patient be in the hospital for only four nights (in most cases).

Block 1 is to remind you that oral contraceptives or estrogens *must* be stopped for three months before renin measurements are made, to be certain that the hypertension is not due to these agents.

TABLE I. Indications for a Thorough Evaluation for Secondary Hypertension

1. Young age
2. Sudden onset
3. Failure of antihypertensive therapy to control blood pressure adequately.
4. Unprovoked hypokalemia
5. Abdominal bruit
6. Abnormal IVP
7. Paroxysmal hypertension

From the Specialized Center of Research (SCOR) in Hypertension, Indiana University School of Medicine, Indianapolis 46202.



*These normal values provided are specific for our laboratory techniques; when different techniques are used or provided by another laboratory, normative data need to be obtained.

FIGURE 1

Block 2 asks questions to determine if the patient is stable enough to undergo the upcoming tests. If the answers to any of these questions are yes, then treatment of these problems and the hypertension should be done first.

Block 3: Drug ingestion may alter renin levels and should be stopped at least two weeks before the patient is admitted to the hospital. If you think the drugs cannot be stopped, then do not measure renin levels! Renal arteriography can, of course, be done even if the patient is taking medication.

Block 4 is a reminder that spironolactone (Aldactone) can affect renin measurements for at least one month and possibly longer. Other drugs will probably be found which have similar effects. Therefore, we feel most comfortable when we minimize these effects by stopping *all possible* drugs for two weeks before admission.

Block 5 recommends that the hypertensive (minute sequence) IVP be done as an outpatient to save a day of expensive hospitalization.

Now that the patient has been off drugs for two weeks and has had an IVP, the next question you must ask yourself is: should I admit the patient to my local hospital or should I send the patient to a "referral center." We believe the tests discussed below can be performed in most hospitals if the following conditions are met.

1. The radiologist is experienced and has the proper equipment to perform selective renal arteriography. This is important because selective renal arteriography will detect lesions that may be missed with only midstream aortic injections. Experience in obtaining renal vein renin samples is also necessary.
2. The hospital nursing staff has been instructed in the use of the protocol and the reasons that the procedures need to be done carefully and at specified times. We have found it most useful to do these studies on

only one ward of the hospital so that the personnel on this ward can become very experienced in the conduct of the protocol. This leads to a smaller likelihood that blood or urine samples will not be collected at the right time or sent to the wrong laboratory. We will be happy to provide interested readers with preprinted order sheets to standardize and simplify the lengthy orders necessary to be certain that the protocol is carried out properly.

3. The hospital laboratory or the laboratory to which the samples are sent has experience in measuring renin and aldosterone levels. These assays are technically difficult to do accurately. Since you may be deciding about surgery based on these results you *must* insist on high quality measurements. You must know what the normal levels are for subjects measured in the laboratory when sent from your hospital. The normal data should include measurements on subjects from age 15 to 55, since age is an important determinant of renin levels. If your laboratory cannot provide you with such normative data, then you should insist that it be obtained or that the samples be sent to a laboratory that can provide such normative data. This point cannot be overemphasized! If your local or referral hospital meets the three major criteria listed above, then you should schedule the patient for admission. An arteriogram is scheduled in advance for the day after admission.

Block 6 is the first day of hospitalization and allows the patient and staff to familiarize themselves with the studies to be done the next three days. We have found that if patients are told what is supposed to happen each day, they will help in ensuring that things are done on time and that mistakes are not

made. If the arteriogram is not to be done, then skip to Block 8 (Day 3).

Block 7: Renal arteriography is performed on this day. If it is abnormal, then you must schedule the patient for renal vein renin measurements on Day 5 (Block 11).

Block 8: On this day you determine if the renin-aldosterone system can be "turned off" or suppressed normally by giving a sodium load. The patient arises at 6 a.m. and walks or stands until 8 a.m. At this time blood is obtained for renin and aldosterone levels. The subject then assumes the recumbent position and is given an intravenous infusion of normal saline at the rate of 500 cc/hr for the next four hours. At noon the IV is discontinued and blood is again sampled for renin and aldosterone.

Block 9: On this day a 24-hour urine is collected for VMA and catecholamines to exclude the possibility of a pheochromocytoma.

Block 10: The purpose of Day 11 is to induce salt and volume depletion to determine if the renin-aldosterone system can be "turned on" or stimulated normally. On this day obtain a renin sample at 8 a.m. after two hours of upright posture and then give the subject furosemide (Lasix) 40 mg at 9 a.m., 1 p.m. and 5 p.m. The diet on this day is limited to 10 mEq sodium (the diet kitchen must be aware of this VERY LOW sodium diet so they can plan ahead for it). Fluid intake is restricted to 25 ml/kg body weight. Remember that the patient can "out-eat" and "out-drink" the furosemide if the diet is not restricted. This, of course, would negate the desired effect of furosemide-induced sodium and volume depletion. Some patients will feel weak on this evening because of the sodium and volume depletion.

Block 11: This day evaluates the subject's response to the volume depletion by measuring renin after two hours of quiet ambulation from 6 a.m. to 8 a.m. Some subjects will not be able to walk this full time due to orthostatic symptoms and

the blood must be drawn at the time that such symptoms occur.

If the patient had an abnormal renal arteriogram on Day 2, then he/she should return to bed and have only a light, salt-free breakfast until renal vein renin sampling can be performed. The importance of performing the renal vein renin sampling carefully cannot be overemphasized, since the decision to operate on a renal artery stenosis is based primarily on these laboratory results. We prefer to collect the samples through two catheters, one in each renal vein, so that the samples can be drawn at the same time. Furthermore, our experience suggests that by tilting the subjects head up to 45° for an additional 20 minutes we will increase the ability to detect significant lesions by 20%. We have found that salt depletion is essential to unmasking a significant renal venous renin difference in most patients with renal vascular hypertension. This is why the sampling is done on the "post-Lasix" day. Our criteria for a significant lesion is that the renin level is at least 50% greater on the side of stenosis than on the normal side. We believe that performing surgery on a patient with renal artery stenosis, without first documenting renal vein differences, will result in a number of unsuccessful blood pressure responses to surgery. Renal artery bypass surgery is not simple surgery! You should refer your patients to someone with considerable experience in this area.

If the patient did not need renal vein renins, then antihypertensive therapy is started in the hospital or the patient may be discharged for further outpatient follow-up.

Block 12: Interpretation of results of the renin-aldosterone meas-

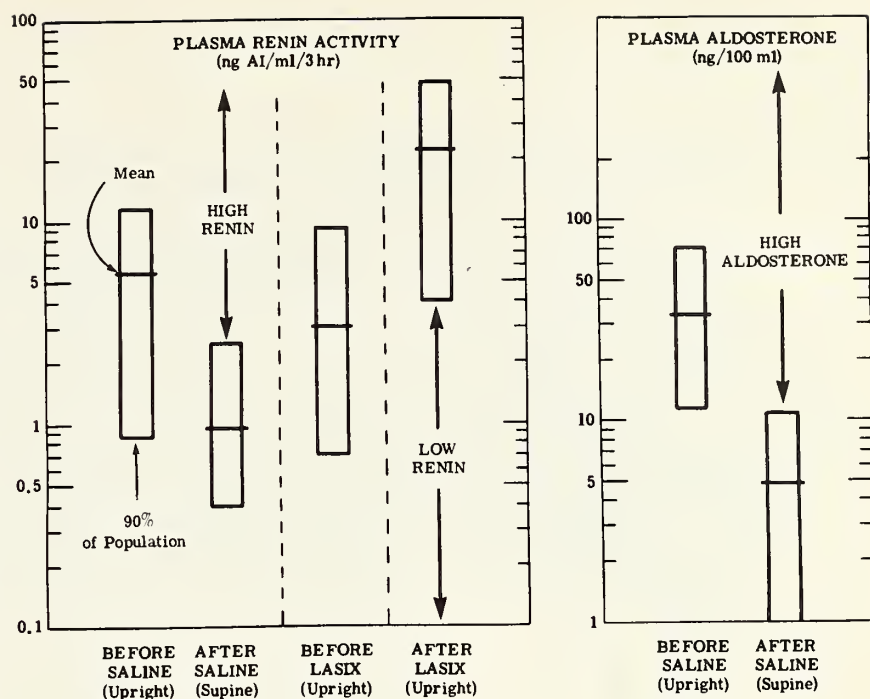


FIGURE 2

urements. Figure 2 provides a normogram on which to evaluate the renin results. This normogram is based on studies in our laboratory in more than 150 normals, from age 15 to 70. First examine the renin level after furosemide. If this is low, then the patient may have primary aldosteronism. To make this diagnosis, look at the aldosterone level after saline. If it is greater than 11 ng%, then your patient has primary aldosteronism and needs further evaluation in a referral center in order to determine if the patient has unilateral or bilateral adrenal involvement, since treatment will be different. If the plasma aldosterone after saline is below 11 ng%, then the patient has "low renin" hypertension and should respond well to diuretics or spironolactone. Next, examine the renin results after saline infusion.

If this is greater than 2.5, then the patient is considered to have a high renin level and should respond well to diuretics and/or propranolol and a vasodilator.

At the Hypertension Center of the Indiana University Medical Center, in a referral setting, we have studied more than 500 patients with this protocol. Of these patients, about 15% have had renovascular hypertension and 5% had primary aldosteronism. We believe this high incidence of secondary hypertension is due to the preselection of patients with secondary hypertension being referred to us. However, no one knows the prevalence of secondary hypertension in your practice. We suspect there are a number with these curable causes. This protocol will enable you to find them. ◀

THE 1977 ROSTER OF MEMBERS—Additional copies of this year's Roster are available. Price to ISMA members is \$5.00; to all others, \$10.00. Please send check with order.

From THE JOURNAL 50 Years Ago

If Indiana is ever to establish modern rural sanitation together with adequate supervision over the country wells and farm dairies such as will be necessary to break the line of typhoid contamination of our food and water supplies, then this state must provide funds in such amount as will be necessary to establish full-time health units throughout the state with trained personnel in charge of the units.

The state is at present paying for its public health work on a basis of less than 6 cents per capita. New York State pays for its public health work 11.6 cents per capita; Rhode Island 13.8 cents and Massachusetts 15.4 cents per capita.

Last year Indiana lost 207 human lives from typhoid fever at a cash value of over \$2,000,000 and about as many more from smallpox and diphtheria, and every one of those deaths was preventable. Public health and the prevention of communicable disease has a definite cash value. It is merely a question of how much a state is willing to pay for its health . . . Walter W. Lee, epidemiologist, State Board of Health, "Typhoid Fever in Indiana," *JISMA*, October 1927.



Statistically, better than two-thirds of physicians' services are being paid by insurance. That is why we designed Medical Data Systems® to include computer preparation of insurance billings. Proven results have included significant reductions in personnel requirements and significant improvement in cash flow. MDS—tailored to meet the needs of group practices—large or small.

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A true murder story, as related by Dr. William Niles Wishard, Sr., in a letter to his son.

The Mysterious "Dr. Billy," Body Snatcher

April 18, 1919

I met Senator New an hour ago down at the street entrance of the Hume Mansur Building and, as Mother and Foff were with me, I introduced them, and in doing so I told Mr. New that I wanted to introduce my old-time partner in body snatching to Mrs. Wishard. There is a story attached to this in which you may be interested.

Forty years ago, or more, when I was a young doctor here, there was a man by the name of Merrick who murdered his wife by giving her poison. He was a liveryman and tried to explain the absence of his horse and buggy one night and some blood stains on the buggy cushion by saying that he often hired this horse and buggy to a man known as "Dr. Billy," who was a body snatcher. As I was deputy coroner at the time and had assisted in making the autopsy on his wife's body, and as I was known by many of my friends as "Dr. Billy," and as the newspapers were full of the story about the mysterious "Dr. Billy," a good many people possibly got it into their heads that I was the original body snatcher. Harry New, who was then a young reporter on the *Indianapolis Journal*, and who came to our office every day for coronatorial news, laughingly accused me of being the mysterious "Dr. Billy." Inasmuch as he talked about it so much, I jocularly accused him of having it on his mind and that he was my side partner in the business.

When the trial occurred it seemed necessary to produce the original "Dr. Billy" and, as body snatching

was a crime, it did not seem probable that the aforesaid individual would be in a hurry to go on the witness stand. However, Judge Heller, of the Criminal Court, and John Elam, the prosecuting attorney, made a private agreement with Dr. Joseph Marsee, who was then Demonstrator of Anatomy in the Indiana Medical College and who had employed "Dr. Billy" to obtain anatomical material for dissection, that if he would produce the original mysterious individual on the witness stand, they would guarantee the aforesaid against prosecution, in view of his helping the State to prove its case against Merrick.

One day while the trial was in progress the prosecuting attorney announced that he desired to introduce Wm. Moffitt, and the judge's private room door was suddenly opened and the "mysterious Dr. Billy" appeared and testified that he was the individual known as "Dr. Billy" and that he had not hired a horse and buggy of Merrick for several months prior to the disappearance of Merrick's wife.

Merrick was hung in the jail yard together with Wm. Achey, another murderer upon whose victim I also made an autopsy, and in both of which cases I was a witness for the State. Just before the trap was sprung, the sheriff, Mr. John T. Presley, with whom I was well acquainted, turned to Merrick and asked him after reading the death warrant, if he had anything to say why the sentence should not be carried into effect. Merrick made a speech in which he denied his guilt and as the jail yard in which he was hung was then located in the corner



of the Court House yard and on the corner of Alabama and New York streets, he dramatically turned toward the Court House just as the clock was about to strike 12 and waved his hand toward it in closing his speech and said "The State of Indiana in the sight of yonder Court House is today doing a great injustice to one of her citizens. I am innocent of the crime of which I am charged."

His wife had been a Miss Paul who lived down near Waverly, where we have often driven together, and her father and brother were present at the hanging. I was standing near them in front of the gallows and, as Merrick made his statement that he was innocent, Mr. Paul replied "That's a lie."

When Merrick's wife's body was found it was nude and buried a few inches under the ground near an old log in the Fall Creek bottoms, southwest of the city. It was mid-summer and very warm and the day it was found was Sunday. Some hogs had been rooting in the ground and had exposed part of the body and someone coming along observed it.

When the body was brought over in town to the undertaker's establishment your grandfather was called to see it; the body was so decomposed that the face was unrecognizable and the identification of the body became a matter of great difficulty. A prominent citizen told your grandfather at the time that it was no use to put the County to the expense of holding an inquest on that body, as nobody could tell whose body it was. Your grandfather replied, however, that the state of decomposition indicated that the woman had been dead not more than a week and that somewhere nearby a woman had been missing for that length of time and that if she had been murdered, as seemed evident, somebody probably knew why somebody else wanted to get rid of her and possibly had heard threats.

I will never forget that Sunday afternoon. I was superintendent of the Seventh Presbyterian Sabbath School at the time and it was held in the afternoon and I had just come home after the close of Sunday School when word came down to our house at 134 Fletcher Avenue for your grandfather to come up and see the body of a woman that had been found in Fall Creek

bottoms. He asked me to go along and make the postmortem. We talked the matter over and he stated his theory and I went ahead and made the postmortem and was careful to tie both ends of the stomach and remove it for analysis of the contents.

His theory that a woman had been missing and that somebody knew why she had been missing proved correct, as he went before the police at roll call at seven o'clock that evening and stated the facts to them and his theory in reference to the same, and at nine o'clock that evening two policemen on the South Illinois beat arrested Merrick.

Your grandfather had requested them to inquire on their beats whether a woman had been missing for the past week and whether any threats had been made against her. It seems that the policemen found someone near the corner of South and Maryland streets who told them that Mrs. Merrick had been missing and it was neighborhood gossip that she and her husband lived very unhappily together. They heard enough to make them suspicious and, upon the ground of their suspicion, they arrested Merrick; yet

they had so little evidence against him then, and he denied his guilt so stoutly, that they took him to a room in the old Palmer House and quizzed him for an hour or two and told him that if he could prove his statements one would stay with him and the other would go and find his wife.

His story was that his wife was about to be confined and she had gone up to stay with a colored woman in the northwest part of town on the canal. She was a midwife and was going to take care of her. He could not even tell the name of the woman or where she lived and yet he acknowledged that he had allowed his wife to go with her. The story was so flimsy that they took him over to the jail and incarcerated him.

At the trial it was proven that he had threatened his wife's life and that she was afraid he would kill her. It was also proven that one week before the body was found late in the evening he had taken the buggy and horse referred to above and his wife and had driven in a northern direction. A saloonkeeper on Indiana Avenue near Michigan Street testified that he had come into his saloon and got two glasses of blackberry wine shortly after the time he should have left his livery barn from which he had taken this horse and buggy. The saloonkeeper said that Merrick drank one of the glasses of wine and said he was going to take the other one out to a woman in the buggy. The saloonkeeper said that when he got near the door he saw him take a piece of paper with a powder in it and put the powder in the glass of wine and stir it up.

A farmer from two miles northwest of town testified that an hour later he heard the screams of a woman and went out to see what was the matter. It was then getting dark and he found a man and a woman in a buggy standing in front of his house and the man told him that the woman was simply drunk and had tried to get out of the buggy and he had put her back.



They drove off together and the next morning when the farmer went out to his front gate he found a laprobe which was afterwards identified by one of Merrick's livery stable employees who had hitched the horse and buggy up for him, as being the one he had put in the buggy on the night Merrick and his wife drove off together, and who said that the laprobe was not in the buggy when Merrick came back alone that night.

Evidently Merrick drove south a couple of miles to the Fall Creek bottoms where his wife's body was found and after her death buried her and her newborn child in the dirt where the two bodies were found. Premature delivery had evidently been induced by the large dose of strychnine which he gave her, and which strychnine was found on chemical analysis of the stomach which I removed from her body.

Your grandfather also found the druggist who had sold the strychnine to Merrick. It was proven that Mrs. Merrick was pregnant and near her full term. Here was evi-

dence of intent on his part, of his purchasing the poison, of his putting it in a glass of wine, of the farmer finding his laprobe, and blood stains were found on the buggy seat which were identified on microscopic examination as human blood cells. It yet remained, however, to prove that this body was the body of Mrs. Merrick. This was conclusively done when your grandfather found the dentist who had filled her teeth and who had a written diagram illustrated at the time he did the work for her, showing the teeth that were filled and the character of the fillings; these fillings were found in the mouth and the teeth of the woman whose body I made the autopsy on.

Mr. Paul, who lived near Waverly, and who is Merrick's father-in-law, was so grateful for the fine detective work which your grandfather did in this case, and for the just punishment which was meted out to his daughter's murderer, that after Merrick's execution he presented your grandfather with a fine horse which Father drove for several years and which we boys

named "Merrick."

The prosecuting attorney and the judge of the Criminal Court during your grandfather's four years as Coroner of Marion County highly complimented and greatly appreciated his keen insight and shrewd understanding of the actions and motives of men whereby he was able to obtain evidence in his coronatorial investigations which was the basis upon which numerous convictions for murder were founded. During this period three men were convicted upon evidence your grandfather obtained and on whose victims I made the autopsy, and one other man was sentenced to be hanged but his sentence was commuted to life imprisonment. Several others were sent to the penitentiary for varying terms.

Pardon this long naration of my youthful professional experiences, but it was all recalled to me since I sat down to dictate this letter by telling you of the simple incident of my introduction of Senator New to your mother and Aunt Genevieve an hour ago.

(Signed) Wm. N. Wishard, Sr.



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MEDICINE AT LAW

State Court Judge May Be Sued For Illegal Authorization Of Sterilization

A judge who without statutory authority permitted the sterilization of a 15-year-old girl did not have judicial immunity from liability under the federal civil rights statutes, a federal appellate court in Indiana ruled.

The patient's mother sought a court order to have her 15-year-old daughter sterilized. She stated that her daughter was "somewhat retarded," although she attended public schools and had been "passed along with other children in her age level." Without her mother's consent, the daughter had begun dating and staying overnight with older youths and men. The mother stated that she could not maintain a continuous observation over her daughter to "prevent unfortunate circumstances."

The state trial court judge issued the requested order in an *ex parte* proceeding. No guardian was appointed to represent the daughter's interest and no hearing was held. The daughter was not notified of the request and neither it nor the order was ever filed in the court. A tubal ligation was performed, and the daughter was told she had her appendix removed.

About four years later, after she was married for two years, she learned that she had been sterilized. She and her husband filed a civil rights suit against the judge. A federal trial court said that the judge was immune from suit, and dismissed the claim.

Reversing the decision, the federal appellate court said that the judge had acted illegally. His action had no support in statutes or Indiana common law and was therefore taken without jurisdiction. He had also violated elementary procedural due process principles of notice, representation by counsel, and opportunity to contest the allegations or appeal the decision, the court said.

Under those circumstances, the judge was not entitled to judicial immunity from the suit by the sterilized daughter and her husband, the court said—*Sparkman v. McFarlin*, 552F.2d 172 (C.A.7, Ind., March 23, 1977.)—*The Citation*, Vol. 35, No. 9, Aug. 15, 1977.

Sherman J. Updegraff

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Informed Consent— Then and Now

"The more things change, the more they remain the same"

AN address by Dr. Henry Jameson before the Marion County Medical Society on Dec. 20, 1898, has been privately reprinted from the *Indiana Medical Journal*.¹ It is a most interesting and instructive dissertation.

As is true with many of the writings of leaders of the medical profession, almost all the philosophical considerations of years ago are still pertinent to the practice today.

A fine example of this is related to the remarks of Dr. Jameson concerning the variability of patients in regard to the amount of information that is proper and may be tolerated by the patient without injury to the curative process.

"Fear of the truth is strong and widespread. It must be a thing familiar in the experience of all how this fear is manifested concerning the knowledge and treatment of disease. The best man, or at least the average man, does not want to know too much of the truth about disease, or of his disease, or too much of the truth about the method of cure; of the two, I believe the fear of the latter is the greater. Many people can face the fact of their ailment without being able to face the truth of the remedy. There lingers in the stoutest hearts sometimes a little timidity of the truth,

a little desire to feel that relief comes by some mysterious means."

"In medicine there is the other well-recognized factor resting on the nervous temperament of the patient, or on some abnormal nervous state, in which knowledge of his condition is not always best. Where, in spite of intention, a special condition of irritability and a general condition of gravity as to the actual power of disease may and does frequently call for trust rather than knowledge—in a crisis of this kind the first duty of the patient is to do, not to know. . . . But in all such cases the last analysis will show that this is because knowledge imparted then would have a deleterious effect on a diseased and abnormal condition, and is entirely apart from the question of facing truth honestly. Such expediency is in the highest interest of the patient."

Informed consent is a recent invention. However, Dr. Jameson's remarks would make an ideal cautionary comment regarding our modern day dilemma with how much a patient should be told.

Many patients maintain emotional equilibrium about their health by steadfastly ignoring it. Such patients, if required to undergo annual clinical testing and physical examinations, would unwittingly transfer their diagnostic category from "well" to "worried well." Only those patients who wish annual checkups should have them. Compulsory annual physicals would

produce more disease (neurosis) than would be discovered, as physical disease in a curable form.

The same philosophy applies to those who approach treatment. Some want to know all about it, others don't. Some do better with knowing everything they can learn about their condition, others are terrified by the details.

Informed consent has been tested by the tape recorder and found wanting. The majority of patients receiving voluminous information about a major operation have been found on review after recovery to remember only a small fraction of what was told them. Some do not even remember the interview.

Patients should have all their questions answered. Beyond this, there are a few items of information about some surgical procedures which should be transmitted even though no inquiry is made. This should be the limit; a complete accounting of everything that can happen during treatment is unnecessary and may be harmful. It is usually not remembered by the patient and, even if it is, the claim may be made in court that, in spite of an hour-long interview, the patient did not fully understand.

The world would do well to follow Dr. Jameson's advice.

¹"The Science of Medicine and Its Relation to the People," reprinted from the *Indiana Medical Journal*, January 1899.

Lobbying Reform: Do It Right

WASHINGTON is a city much given to cures worse than the disease. The lobbying reform legislation being contemplated by Congress furnishes ample evidence of that problem.

Some kind of reform is certainly needed, partly because of the real abuses which occasionally occur and especially because of the numerous defects of the existing law.

But such abuses as there have been hardly justify the serious threats to our constitutional liberties that have slithered into some of the "reform" bills.

What's wrong with the present rules? As things now stand, individuals or organizations must register and file reports with the House and Senate when, among other things, their "principal purpose" is to influence national legislation.

How do you decide what your principal purpose is? No one seems to know. This elusive and subjective requirement places conscientious people in the untenable position of not knowing what they must do to comply with the law. For the same reason, the vague language has made a farce of enforcement, which is no longer even attempted.

This situation, plus the scandals of recent memory, have given rise to numerous pieces of "reform" legislation.

Consequently, both the House and the Senate are now considering lobbying reform bills that would inhibit the discussion of legislation in private newsletters, compel private organizations to disclose their mem-

bership lists, classify as "lobbying" the process of informing the members of an organization about legislation of interest to them, impose complex and costly burdens of red tape both on the "professional" lobbyist and on those who make only incidental and infrequent contacts with Congress, and hold over the heads of all the threat of criminal penalties for failure to comply with these draconian regulations.

Anyone who doesn't recognize such proposals as a serious threat to the constitutional rights of petition, free speech, free press and assembly is dangerously naive. Indeed, with respect to disclosure of membership lists the Supreme Court has consistently recognized that "... compelled disclosure can seriously infringe on privacy of association and belief guaranteed by the First Amendment."

Compelled disclosure was, in fact, one of the tactics used by recalcitrant state governments against the National Association for the Advancement of Colored People during the early days of the civil rights struggle. It is wrong because it permits partisans to learn the identity of the members of an opposing organization in order to harass or intimidate them individually.

Inhibition is the net effect of all these rules taken together. Obviously, many individuals and organizations would refrain from presenting their views to Congress if they had reason to fear criminal penalties for failure to comply with complicated procedures requiring the advice of a lawyer to fathom.

In any case, many of these heavy-handed reform proposals are born of a popular misconception of lobbyists as sinister types who head for Capitol Hill with lots of money in their pockets and no votes and leave it with lots of votes and no money. Sure it has happened. But it's not common. That kind of activity is ultimately counterproductive and the truly Washington-wise know it.

What should a good lobbying reform bill embody?

It should be simple and easy to understand.

It should be fair and equitable in its coverage.

It should have reasonable reporting requirements which are not so complex that they inhibit the free expression of opinion.

It should not apply to persons who contact Congress infrequently.

It should not have a "chilling effect" on the exercise of the rights of petition and assembly.

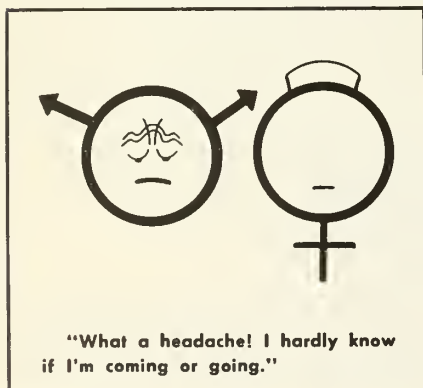
Anything that goes very far beyond these simple requirements is likely to be a greater evil than those it purports to prevent.—**Richard L. Leshner, president, Chamber of Commerce of the United States.**

Editorial Notes...

Everyone should be taught that cardiopulmonary resuscitation, promptly applied, is usually the only treatment needed when a person is rendered unconscious by a lightning stroke. Universal paralysis is the cause of the cardiac and respiratory arrest and, like any other cardiac arrest, if resuscitated immediately will not produce brain damage.

The cost of raw materials for the pharmaceutical industry has risen 68% in the past 10 years; the prices for prescription drugs have risen only 23.8%. In the same time wholesale prices have climbed 82.9%. Good drugs are still the best bargain in the country.

The increase in productivity in the pharmaceutical industry in 1975 was double that in the nonfarm business sector. The Labor Department reports gain of 7.3% for drugs and 3.7% for others. Productivity is measured by determining output per hour of work. The improvement is said to be associated with the general economic recovery. ◀





BOOK REVIEWS

TO EMPOWER PEOPLE. THE ROLE OF MEDIATING STRUCTURES IN PUBLIC POLICY.

Peter L. Berger and Richard J. Neuhaus, American Enterprise Institute for Public Policy Research, Washington, D.C., 1977; 45 pages, paperback, \$2.50.

This small but meaty book is actually a first report on a research project intended to explore this area, partially funded by the National Endowment for the Humanities. Others are also involved in the research, to include five "broad policy areas": health care, housing and zoning, welfare and social services, education and child care, and criminal justice. Berger and Neuhaus are co-directors of the project, begun in 1975 and expected to continue through 1979.

The "mediating structures" comprise the family, the neighborhood, the church, voluntary associations, and ethnic and racial subcultures. It is hoped that these institutions, or entities, can be used to deliver social services now being attempted through government bureaucracies. Neuhaus is a Lutheran minister who has been active in city affairs, civil rights and antiwar movements, while Berger is professor of sociology at Rutgers University, and a well known conservative author. Both are editors of *Worldview*, monthly journal of religion and international affairs.

It will be refreshing to most physicians to find not just one, but two sociologists (professionals, at that) who are unhappy with proposed imposition of uniform (a la "1984") solutions to "natural social problems" upon the American people. For this reason, I can recommend heartily a perusal of this book by my doctor friends and would suggest they urge that copies be made available in their local public libraries.

A. W. CAVINS, M.D.
Terre Haute

Teach 'em, Inc. has published "Health Controls Out of Control—Warnings to the Nation from Massachusetts," a book by David Kinzer, president of the Massachusetts Hospital Association. It is written to show how government regulations interfere with proper hospital administration. Kinzer makes two dozen proposals for reform. 212 pages, \$9.75.

* * *

Epic has published a book for the National Joint Practice Commission. The title is "Together: A Casebook of Joint Practices in Primary Care." It is a collection of 24 examples of joint M.D.—R.N. practice from all over the country, one of which is in Greencastle, Indiana. The general editor is Berton Roueche, author of many books on epidemiology and contributor to *The New Yorker Magazine*.

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* * *

Narco Air-Shields has a completely controlled environment for emergency transport of neonates. The transport incubator provides easy observation and access and a three-position adjustable stand which allows movement within the hospital or between hospital and vehicle. It is powered by a Gel-type D.C. power source with adequate power for long trips.

* * *

The Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, MI 48105, has a new 1977 CPHA Review Date Calculator. It is an aid in identifying initial or extended review dates. Said to be a handy tool for review coordinators and record room personnel. Sells for \$5.00 (\$4.50 each for orders of two or more).

* * *

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Spectra Industries has a new and unique foot orthosis which provides universal adjustment in all planes. It is for children and, without the use of orthopedic shoes, provides for infinite internal and external rotation, up to 30° eversion or inversion adjustment, up to 30° dorsi or plantar flexion adjustment and adduction or abduction from 14 inches to 4 inches in 1-inch increments.

* * *

Litton Medical Electronics announces a new Servomed Oxymonitor for non-invasive monitoring of the partial oxygen tension in the blood. It provides continuous, transcutaneous measurements with the aid of a small transducer. It is applied directly to the skin and within 20 minutes provides real-time measurements in both digital display and analog record trace.

* * *

"Human Population Genetics" has been published by the U.S. Department of Commerce, to discuss basic principles of population genetics and to demonstrate the application of these principles in genetic screening and counseling. Papercopy (29 pages) \$4.00. Write the Department, National Technical Information Service, Sales Desk, 5285 Port Royal Road, Springfield, VA 22161.

* * *

Pilling has a new flexible bronchoscope. It features an angulation system with control knob and may be controlled with one hand. It has the narrowest available outside diameter and still has a relatively large inside diameter which will accommodate larger forceps than will other scopes. Forceps are calibrated in length so that over-penetration is avoided.

* * *

Ortho Pharmaceutical has a new prescription drug product, IMODIUM™ (loperamide HCl), for the control and symptomatic relief of acute nonspecific diarrhea and of chronic diarrhea associated with inflammatory bowel disease. It will also reduce the volume of discharge from ileostomies. It does not contain atropine.

* * *

Media Learning Systems announces two teaching aids for instruction to laymen regarding rescue procedures for people who are choking. An audiocassette combined with a worksheet sells for \$9.98. A deluxe color slide/sound show is priced at \$69.98.

* * *

Power Instruments of Skokie, Ill., announces a new tachometer for medical use. Without contact with the machine whose RPM is to be measured, the Photo Tach will, from a distance of up to 20 inches, give a direct reading of RPM up to 30,000 with an accuracy of plus or minus 1 RPM. Especially good for centrifuges.

* * *

Ames announces a new foil-wrapped package of MICROSTIX-3. It consists of 3 reagent strips for urinalysis—3 dip-and-read strips for nitrite and culture test for total bacterial count and Gram negative bacterial count. The package has a long shelf life and is an improvement over the original packaging which involved two separate containers.

Yes! It's Working!!

GILBERT M. WILHELMUS, M.D.
Evansville

IN 1975 the Indiana General Assembly passed P.L. 146, The Medical Malpractice Act, in hopes of alleviating the medical liability crisis which was threatening the continuation of the existing health care delivery system in our state.

As one looks back at this "Monster" that existed in our midst, one can clearly see that it consisted of two heads.

The first head represented the increased number of medical litigations which were occurring along with the growing amount of settlements. As the first head continued to grow, it caused a catalytic reaction that stimulated the growth of the second head of the "Monster"—the unavailability of medical liability insurance. In many instances the physician being canceled, or the new physician entering the market, was unable to obtain medical liability coverage at any price.

One of the documented facts that precipitated the passage of P.L. 146 was that in the early part of 1975 one medical liability carrier, which insured 52% of the physicians, had 51 new medical liability cases filed within a six-week period.

But, the legislators felt strongly that this piece of legislation should be carefully watched and improved, if needed, and, therefore, created a Medical Malpractice Study Commission as part of the Act. The Study Commission did recommend improvements to P.L. 146 in 1976 and 1977, and the legislators reacted in an affirmative manner. The committee consisting of 13 members includes: Gilbert M. Wilhelmus, M.D., chairman; Senator Leslie DuVall, Representative Joseph P. Harris, Representative Philip T. Warner, Mr. William Davey, Mr. Don Hamachek, Mrs. Betty Mummaw, Mr. Willis Zagorvich, Mr.

Charles Hoodenpyl, William Cast, M.D., Mr. H.P. Hudson, Senator Adam Benjamin and Mr. John Carr. The two latter are no longer with the committee. They have been replaced by Mr. Karl Stipher and Senator Robert E. Peterson. On Aug. 4, 1977, a report was given to the Study Commission by various members of the Commission explaining what had transpired since the Medical Malpractice Law was passed. A resume of the major points follows:

Statute of Limitations—All new medical liability suits will be covered under the Malpractice Law (P.L. 146). No one will be liable for suit for an act committed before July 1975—except for a child under six years of age.

Screening Panel—There have been requests for panel review of 61 cases since the inception of our law in July 1975 through Aug. 1, 1977. So far, only a small number of the panels have completed their deliberations and issued final findings. It may be noted that approximately one half of the findings were in favor of the plaintiff and one half in favor of the defendant. Many cases (207 in number) have been settled without panel review. Most of these cases are of a general liability standpoint rather than from a medical malpractice standpoint: e.g., a patient falling from a hospital cart.

Malpractice Residual Authority—The Malpractice Residual Authority is the entity where health care providers can obtain liability insurance if they are unable to obtain insurance from the volunteer insurance market. This usually involves people with multiple law suits, although this is not always the case.

At this time there are 613 providers insured with the Authority—354 doctors, 2 hospitals, 2 dentists, and 180 other allied health care providers. As time progresses, the number of health care providers insured by the Authority is decreasing. This has been brought about by the continuing improvement of the medical liability climate in the state of Indiana and, as a result, these providers are able to obtain coverage from the open market. Even though these providers are of a high risk group, only 15 claims have been filed against the Authority—seven of the cases have been settled and eight remain unsettled.

Patient Compensation Fund—This fund consists of 10% of the health care providers' annual premiums. The total amount which has been collected to date is \$4,952,684.91. This amount, combined with the interest earnings of \$157,801.11, makes a total accumulation in the Patient Compensation Fund (as of Aug. 1, 1977) of \$5,110,486.02. Since no claims have been settled on the medical liability problem in Indiana for more than \$100,000, the Patient Compensation Fund has had no known claims of liability to date. However, it should be noted that there are still several cases pending panel review, thus making it impossible to know what impact they may have on the Patient Compensation Fund.

Medical Protective Insurance Company—This company is covering over 80% of the practicing physicians in our state. A comparison of insurance service office rates to other states was given. The fact was very quickly noted that the Indiana rates are among the lowest in the country for which this company is writing insurance.

RATE LEVEL COMPARISON

Medical Protective Insurance Company
(10% surcharge for Indiana not included)

	CL. 1	CL. 2	CL. 3	CL. 4	CL. 5
Indiana (1/77)	593	988	1632	2814	3830
Illinois (1/77) (Chicago)	1128	1382	2839	6333	9887
Michigan (1/77) (Detroit)	1383	2064	3887	6112	9156
Ohio (1/77)	1333	1712	3335	5606	8153

I. S. O. Comparison

	CL. 1	CL. 2	CL. 3	CL. 4	CL. 5	CL. 6	CL. 7
Indiana (1/77)	922	1659	2991	3985	4982	5979	7973
Illinois (1/77) (Chicago)	1032	1548	3096	5160	7224	8256	10320
Michigan (1/77) (Detroit)	2240	4480	8966	11200	13490	—	—
Ohio (1/77)	1401	2523	4275	5699	7126	8551	11402

Some insurance companies have merit ratings for physicians—one lawsuit, the physician pays 30% surcharge; second lawsuit, the physician pays 50% surcharge.

Self Insurance—Only one hospital has qualified under the “Self Insured” plan. In fact, no other type of health care provider has applied to qualify under the plan.

Constitutionality — The constitutionality of our law is being contested in a circuit court. At this moment things look very favorable for our law being held constitutional. An opinion on this ruling will probably be given in the latter part of November.

Let's Look at Some of the Other States in the Midwest

Kentucky: Recently an unfavor-

able ruling was given by the Supreme Court of the State of Kentucky on the constitutionality of its law. It appears that the reason for the Supreme Court ruling was that it mandated each health care provider to have insurance. It also held that the law could not obligate future state funds in the event the Patient Compensation Fund becomes insolvent. The Indiana law does *not* contain either of these provisions.

Nebraska: Nebraska's courts have studied the Nebraska law, which is very similar to the Indiana law, and have given it an excellent ruling on every item throughout the law. They ruled that the malpractice law in the state of Nebraska is constitutional.

Yes! It's Working!! There has

been a tremendous drop in the amount of medical litigations which were occurring. The amount of settlements have drastically reduced. The availability of medical liability insurance for health care providers is present. Every physician in the state of Indiana can obtain medical liability coverage. The insurance rates for the medical liability coverage are among the lowest in the country. The Indiana State Medical Association, the physicians, and other health care providers, and especially the citizens of the state of Indiana who helped pass our malpractice law, should be pleased that *IT IS WORKING!!*

1028 Washington Ave.
Evansville 47714

AMA House of Delegates approved a proposal to discontinue the scientific portion of June conventions (after the 1978 Annual Convention), thus shifting resources to permit expansion of the Winter Scientific Meeting and the Regional Scientific Programs. The proposal was based on research showing physician continuing education preferences by time, season, location and format. The action included delegation to the Board of Trustees of the selection of sites for House meetings, a change that will require a vote to amend the Constitution and Bylaws at the 1977 Interim Meeting.

THE AMA'S 31st WINTER SCIENTIFIC MEETING will be held Dec. 10-13 at Miami Beach.



Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

Most Widely Prescribed—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

Relief of Nausea and Vomiting—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.

Dosage for Vertigo*—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg/kg/day in rabbits and 10 mg/kg/day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children. Clinical studies establishing safety and effectiveness in children have not been done, therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy. See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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* Warning

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

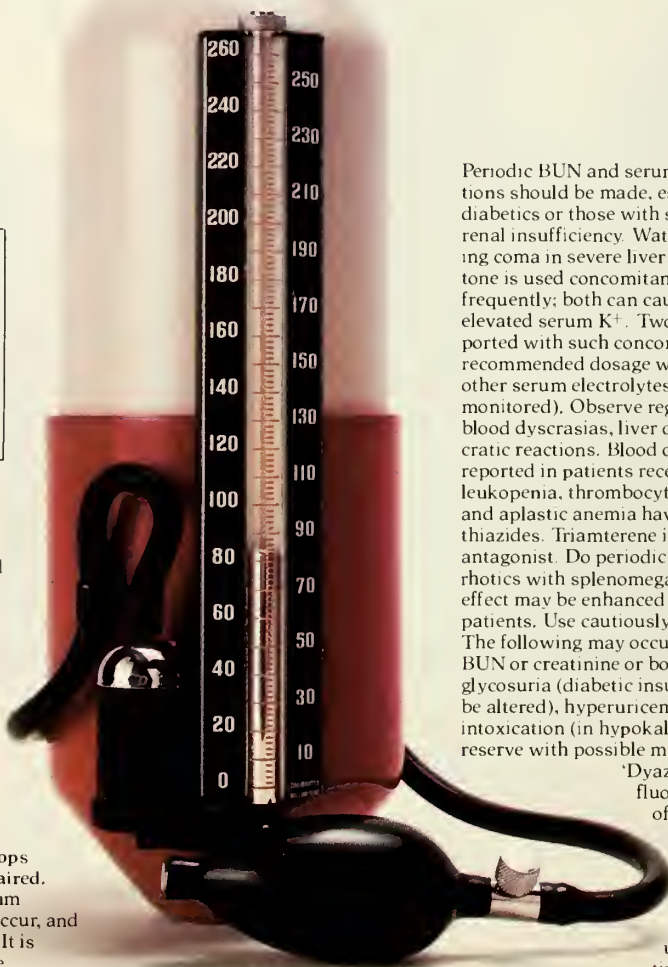
Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

**FOR LONG-TERM CONTROL
OF HYPERTENSION*
SERUM K⁺ AND BUN SHOULD
BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)**

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Two Indiana Jails Among 16 Accredited by AMA

TWO Indiana jails—those in Greene and Marion counties—were among the first 16 jails in the United States ever accredited by the American Medical Association as providing adequate medical care and health services for inmates. The other 14 jails are in Georgia, Maryland, Michigan, Washington state and Wisconsin.

Certificates were presented at a special ceremony held at the National Jail Conference in Milwaukee on Aug. 21. Sheriff Orval Byers accepted the certificate for the Greene County jail, Bloomfield, and Sgt. Larry Biggs accepted the certificate for the Marion County jail, Indianapolis.

The accreditation procedure is part of a program developed by the American Medical Association which has been financed by the Law Enforcement Assistance Administration of the U.S. Justice Department with the cooperation of the National Sheriffs Association and the American Correctional Association.

The AMA Pilot Project, which has been in operation in the six states since January 1976, has produced the first set of national, operational medical standards for

jails in the history of the American correctional system.

The certificates were presented by Dr. Herbert C. Modlin, chairman of the AMA Jail Project Advisory Committee, who said:

This represents an important milestone in the American correctional system. The lack of adequate medical care in the nation's jails has been a disgrace. Medical societies have played an important role in helping to develop model health care systems. For the first time our jails have been meticulously examined against recognized standards. A number of them have met the test.

The standards, consisting of 83 separate criteria for medical care and health services in jails, represent the consensus of the AMA and state advisory committees of physicians, nurses, sociologists, criminologists and ex-offenders. To be accredited, a jail must meet at least 90% of the criteria.

Dr. Dwight W. Schuster, Indianapolis, has served as chairman of the Indiana State Medical Association's Ad Hoc Committee on the Improvement of Medical and Health Care in Jails since its inception. ◀



LT. RUSS FREELAND and Sgt. Larry Biggs of the Marion County jail staff display the certificate just presented to the Indianapolis facility by AMA Jail Project Chairman Dr. Herbert Modlin (right). ISMA Executive Director Donald F. Foy (third from left) and Jail Project Coordinator Mike Huntley look on.



SHERIFF ORVAL BYERS, Bloomfield, (left) accepts the certificate awarded to the Greene County jail at the National Jail Conference held in Milwaukee recently. Presentation was made by Dr. Herbert Modlin for the AMA, and ISMA Executive Director Donald Foy (second from left) and Jail Project Coordinator Mike Huntley witness the presentation.

The Auxiliary Reports to ISMA



I am happy to present the chairmen of our Legislation Committee, Alfrieda (Mrs. Frederick) Mackel of Hometown and Karen (Mrs. Robert M.) Schleinkofer of Fort Wayne, who are our guest columnists this month.

Mary K. Stanley

Mary K. (Mrs. John R.) Stanley
President, ISMA Auxiliary

The need to be informed on medical legislative issues should be the priority of every physician's spouse. As we all are aware, the government has set more and more guidelines for the practice of medicine. The future can only hold more restrictions. We challenge every spouse to study the issues. One of the best ways is to read the **AMA News**, especially "Washington Week."

The auxiliary has a system of LEGS Alert (Legislative Effort Group System). Anytime there is pending legislation unfavorable to medicine, the AMA notifies the state chairman, we notify the county chairman and they, in turn, alert their local members. Letters are then written to our congresspersons defining the bill and the objections to it. You can see our need to have a contact in every county auxiliary or, if unorganized, a contact person in each county.

One of the big issues will be National Health Insurance. There are three main bills: the AMA plan—The Comprehensive Health Care Insurance Act of 1977, The National Health Care Act, and the Health Security Act supported by Senator Kennedy. Watch these bills closely.

In January we will have a 'Meet Your Legislator Luncheon.' At this time we have lunch informally with our state congresspersons. Before lunch we will hold a briefing session on current issues and, after lunch, when our legislators are back at work, we will have a speaker from the AMA. We hope many of you will take time to join us.

ALFRIEDA MACKEL
KAREN SCHLEINKOFER
Legislative Chairmen

When **impotence** due to androgenic deficiency is driving them apart



Android®-5 Buccal
Tabs

Android®-10 Oral
Tabs

Android®-25 Oral
Tabs

Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 vs. Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101, Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

FUTURE MEETINGS, SEMINARS, COURSES

Ongoing CME Opportunities Available At Indiana University Medical School

Two leaflets just released by the Indiana University School of Medicine detail ongoing continuing medical education opportunities at the I.U. Medical Center in Indianapolis.

These activities, open to all Hoosier physicians who wish to update their knowledge and skills in certain fields, include clinical conferences, lecture series, departmental rounds, grand rounds, seminars, scientific conferences, journal sessions and other events. The program, which is on a weekly basis throughout the school year, also offers three continuing features on WAT-21, the closed-circuit medical television station, which is linked to about 30 hospitals throughout the state.

Provided by the clinical departments of the School of Medicine, the courses were designed basically for graduate education (resident training), but have been opened to the practicing physician. Departments involved include anesthesiology, dermatology, family medicine, medical genetics, medicine, neurology, obstetrics and gynecology, ophthalmology, orthopaedic surgery, otorhinolaryngology, anatomical pathology, pediatrics, psychiatry, radiation oncology, radiology, urology and surgery.

Physicians who wish to participate should contact the department to be sure that space is available.

Further information may be obtained from the Division of Postgraduate and Continuing Medical Education, I.U. School of Medicine, 1100 W. Michigan St., Indianapolis 46202. This division sponsors more than 40 short courses in continuing medical education varying in length from one day to two weeks during the school year.

Postgraduate Courses in Michigan

The University of Michigan announces the following postgraduate courses, all of which will be held at the Towsley Center in Ann Arbor:

Date	Title	Target Audience
Oct.		
17-21	Family Practice Review I	Family Physicians
24-25	The Sibley W. Hoobler Symposium: Causes, Management and Control of Hypertension	
27-29	Plastic Surgery in General Surgical Practice	General Surgeons
Nov.		
4-5	Practical Application of Developmental Knowledge	Psychiatrists, Mental Health Professionals
9	Cardiology for Family Physicians	Family Physicians
11-12	Mammography for Radiologic Technologists	Radiologic Technologists
17	Psychopharmacology	Primary Care Physicians, Psychiatrists

Complete information is available from the Department of Postgraduate Medicine, Towsley Center for Continuing Medical Education, Ann Arbor 48109.

"Hyperlipidemia Management" Topic

"Office Management of Hyperlipidemia" will be the subject of symposium to be held from noon until 5:30 p.m. at the

Sheraton Oak Brook Hotel in Oak Brook, Ill., on Nov. 9. It is sponsored by Rush-Presbyterian-St. Luke's Medical Center and the Chicago Heart Association with a grant from Dow Pharmaceuticals. The registration fee is \$15, which includes the sessions, lunch and coffee break. Residents, interns and medical students may attend without charge. Write the Medical Center at 1753 W. Congress Parkway, Chicago 60612.

Conference on Pulmonary Function: New Concepts, Techniques, Announced

"Pulmonary Function: New Concepts and Techniques" will be the subject of a postgraduate course November 10 to 12, in Lexington, Ky. The sponsors are the University of Kentucky Medical Center and the Veterans Administration Hospital. Registration fee is \$275. Sixteen hours credit will be granted.

"The Year of Primary Care" Theme of Fort Wayne Medical Education Program

The Fort Wayne Medical Society's Committee on Postgraduate Medical Education has planned its 1977-78 series around the theme "The Year of Primary Care," as follows:

- Nov. 1—The N. L. Salton, M.D., Memorial Lecture: "New Ways to Diagnose and Treat Infections," Robert Fekety, Jr., M.D., Professor of Medicine, Head of Infectious Diseases Division, University of Michigan.
- Dec. 6—IAFP Road Show. An afternoon and evening program on the results of the AAFP—University of North Carolina Department of Epidemiology study on Utilization and Assessment of Primary Care in Fort Wayne.
- Jan. 3—Cancer Symposium: "Cancer and Estrogen Therapy," Alvin F. Goldfarb, M.D., Professor of Ob-Gyn, Jefferson Medical College, Philadelphia.
- Feb. 7—Heart Symposium: "Hypertension Update—1978," afternoon and evening program featuring nationally known authorities.
- Mar. 7—Father-Son-Daughter Banquet: A female tennis professional will be the speaker for this annual affair.
- Apr. 4—"Treatment of Hypertension—The Pharmacology and Its Role in the Selection Process," Norman M. Kaplan, M.D., University of Texas Health Sciences Center, Southwestern Medical School, Dallas. (Supported in part by a grant from Boehringer Ingelheim, Ltd.)
- May 2—The First Francis E. Sarver, M.D., Memorial Lecture, to be presented in cooperation with the Fort Wayne Surgical Society.
- May 23—Annual Meeting; joint meeting with Auxiliary for installation of officers.

All meetings are at the Shrine Club except the last, which will be held at the Fort Wayne Country Club.

The September program featured a lecture by Dr. B. Leslie Huffman, current president of the American Academy of Family Physicians, while the October session, which was sponsored in part by a grant from the Upjohn Company, featured a talk on "Newer Nonsteroidal Anti-Inflammatory Agents" by Dr. Samir Yehia, chairman of the Department of Medicine, Henry Ford Hospital.

Bones, Joints, Bursae Subject of St. Mary's Family Practice Seminar

The annual Family Practice Seminar sponsored by the Graduate Medical Center of St. Mary's Hospital, Evansville, has been announced for Thurs., Nov. 10, 1977, commencing at 1 p.m. Subject will be "Bones, Joints, Bursae," and the speakers and their topics are:

Dr. Vincent DiStefano, University of Pennsylvania: "Spine Injuries and Problems."

Dr. William O'Brien, University of Virginia: "Bursitis, Fibrositis or Myositis."

Dr. John Hurst, Emory University: "Arthritides."

Dr. Joseph Kutz, University of Louisville: "Reconstructive Procedures for Severe Arthritis."

Seminar on Ambulatory Care Quality

"State of the Art of Measuring Quality of Ambulatory Care" is to be the subject of a two-day seminar at the Case Western Reserve University School of Medicine on Dec. 1 and 2. Direct inquiries to William H. Kincaid, CWRU School of Medicine, Cleveland 44106.

Human Infertility Symposium Planned

A symposium on "Human Infertility" will be conducted in Atlanta on Dec. 9 and 10. A distinguished faculty will discuss the various aspects of the problem. The Xytex Corporation is sponsoring the meeting and will give further information if written to at 1519A Laney Walker Blvd., Augusta, Ga. 30904.

Tel Aviv Symposium Announced

An International Symposium on the Dying Human will be held in Tel Aviv, Israel, Jan. 15 to 20, 1978. Write to Professor Andre de Vries, P.O. Box 16271, Tel Aviv, Israel, for details.

Family Medicine Review at Lexington

The Eighth Family Medicine Review, Session III, will be conducted Feb. 19 to 24, 1978, at the Hyatt Regency Hotel in Lexington, Ky. Registration fee is \$295. Fifty hours credit for AAFP and for Category 1 with the AMA. For more details write Dr. Frank R. Lemon, College of Medicine, Lexington 40506.

Ob-Gyn Conference in Hawaii in April

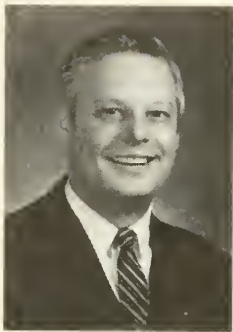
The Obstetrics and Gynecology Department of the University of Kentucky College of Medicine is sponsoring a medical program entitled "Controversies in Care," to be given on Maui, Hawaii. The dates are Apr. 18 to 25, 1978. Package fee is \$850. The trip will originate in Cincinnati and 30 hours credit will be granted.

Drug Abuse Symposium in Israel

The 4th International Symposium on Drug Abuse will meet in Haifa, Israel, June 12 to 15, 1978. Write to The Secretariat, P.O. Box 16271, Tel Aviv, Israel, for full particulars.

A FINANCIAL CONTRIBUTION has been received from Bristol Laboratories, CIBA Pharmaceutical Company, Immke Circle Leasing, Inc., Eli Lilly and Company, Mead Johnson Laboratories, The Medical Protective Company, Merck Sharp & Dohme, Parke, Davis & Company, Professional Management, A. H. Robins Company, Schering Corporation, Searle Laboratories, E. R. Squibb & Sons, Inc., The Upjohn Company and Wyeth Laboratories.

OCTOBER						
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23	24	25	26	27	28	29
ISMA 1977 ANNUAL MEETING Hyatt Regency Hotel • Indianapolis						
30	31	NINETEEN SEVENTY-SEVEN				



TAX TIPS

LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

Introduction

With this article, I shall commence my discussion of the estate tax changes which were made by the Tax Reform Act of 1976. In so doing I shall integrate the changes into the former framework of the law. And, as a preface, I shall observe, as I did in my discussion of the gift tax law, that most of the estate tax changes are applicable to transfers (or other activities) which occur after Dec. 31, 1976, that is, to transfers (or other activities) which are made by decedents who die after Dec. 31, 1976. As an additional preface, I might briefly discuss the reasons why the new gift and estate tax law is referred to as a *unified* tax law.

The unification of the new gift and estate tax law cannot be seen by looking to the gift tax law alone. However, when examining the new estate tax law it is readily apparent that various estate tax results cannot be determined under the estate tax law unless certain facts are known (and, in some cases, certain computations are made) concerning the gifts which were made by the decedent during the decedent's lifetime. Of course, under the former law, there were several relationships which existed between the former gift tax law and the former estate tax law, and, in one sense, these relationships are unification aspects.

For the most part, these former relationships continue under the new law. For example, if a decedent gives away an interest in property during the decedent's lifetime and reserves another interest in the property until the decedent's death, then the entire value of the property may still be includable in the decedent's gross estate under §2036, §2037, or §2038. In addition, if the decedent was subject to *gift* taxation on the trans-

fer of the property during the decedent's lifetime, and subject to estate taxation on the assumed transfer of the property at the decedent's death, then, in general, the decedent is still entitled to a credit against the estate tax (though the computation is somewhat different under the new law) for the amount of gift tax which the decedent so paid. On the whole, I do not intend to discuss these *continuing* relationships. Instead, I shall comment on the former relationships which have been introduced by the new law.

There are four general areas of the estate tax law which have been changed in order to make the gift and estate tax laws more unified—namely, the statutory provisions which pertain to: the decedent's gross estate, the decedent's estate tax deductions, the estate tax, and the credits against the estate tax. Of course, these are not only changes in the gift and estate tax laws—just the changes which made the gift and estate laws more unified.

More specifically, the new estate tax law has changed two sections which concern the value of property which is includable in a decedent's gross estate. That is, former §2035, which dealt with gifts in contemplation of death, has been changed in order to eliminate the rebuttable presumption—that all gifts which were made within three years of a decedent's death were made in contemplation of death and, therefore, includable in the decedent's gross estate. In lieu thereof, §2035 now provides that certain gifts which a decedent makes within three years of the decedent's death are automatically includable in the decedent's gross estate—regardless of the decedent's intent in making the gifts. Also, §2040, which dealt (and still does) with property which a decedent owned with rights of survivorship, has been changed in order to provide in general, that if such property is owned by spouses and if the creation of their interests (by one or both of them) was subject to gift taxation, then one half of the value of the property will be includable in the gross estate of the first spouse who dies.

In addition, the new law has increased the estate tax marital deduction, but in certain cases the new law requires the estate tax marital deduction to be reduced due to the decedent's lifetime use of the decedent's gift tax marital deduction. Further, the new law eliminates the \$60,000 personal exemption of the estate tax (as the new law did for the \$30,000 personal exemption of the gift tax).

Further, the new law replaces the former, separate, gift tax and estate tax rate schedules with one rate schedule which is applicable to both gifts and death transfers. And, the method for applying the estate tax rates has been

changed so that the application is similar to the application of the rates under the gift tax law. In so doing, the application of the estate tax rates now takes into account the amount of taxable gifts which a decedent has made during the decedent's lifetime. Thus, a decedent's estate tax will be affected by the amount of taxable gifts which a decedent has made during the decedent's lifetime.

Finally, the estate tax has been changed in order to provide each decedent a fixed estate tax credit, which credit is similar to the new gift tax and which credit is, in effect, reduced by prior uses of the new gift tax credit (and reduced by certain uses of the former \$30,000 gift tax personal exemption).

Estate Taxation

In general, the Tax Reform Act of 1976 has done nothing to change the basic *method* for computing the *taxable estate* of a decedent. That is, prior to the new law the taxable estate of a decedent was computed by the following three basic steps, namely:

Gross estate	\$
Less:	
Claims	
Funeral expenses	
Administrative expenses	
Casualty losses	
Adjusted gross estate	\$
Less:	
Charitable contributions	
Marital transfers	
Personal exemption	
Taxable estate	\$

After the new law, the computation of a decedent's taxable estate is as follows:

Gross estate	\$
Less:	
Claims	
Funeral expenses	
Administrative expenses	
Casualty losses	
Adjusted gross estate	\$
Less:	
Charitable contributions	
Marital transfers	
Minor children transfers	
Taxable estate	\$

Thus, aside from the two changes in the computation of a decedent's gross estate (concerning gifts in contemplation of death and property held jointly with rights of survivorship), the only two significant changes in the *form* of the computation of taxable estate are that (1) the *personal exemption* has been deleted, and (2) a new deduction has been added—namely, a deduction for transfers

to *minor children*. However, as I have mentioned and as I shall discuss in detail in a later article, the computation of the estate tax (once the taxable estate has been determined) has significantly changed.

There are 12 estate tax sections which require the transfers of certain property to be included in a decedent's gross estate (§2033 through §2044). The Tax Reform Act of 1976 made no changes in the first two of these sections (§2033 and §2034). Thus, in general, §2033 continues to require that all property in

which a decedent has an interest at death and which passes, by reason of the decedent's death, to another person is includable in the decedent's gross estate. This includes, for example, property which the decedent owns in the decedent's own name and the decedent's interest in property which the decedent owns as a tenant in common. This does not include, however, property which is held by the decedent and another person with rights of survivorship. Further, §2034 continues to require a decedent to include (in the gross estate) the full

value of the decedent's various interests in property—undiminished by any marital interest which the decedent's surviving spouse might have in the decedent's property.

Thus, the first major change in the sections which define the types of transfers which are includable in a decedent's gross estate is the radical change in §2035, which section used to be applicable to "gifts in contemplation of death." I shall devote my entire next article to a discussion of the changes to this section. ◀

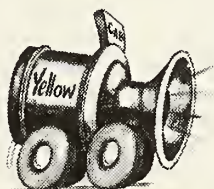


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Deaths

Samuel S. Caplin, M.D.

Dr. Samuel Shlame Caplin, 65, retired Indianapolis physician died Sept. 11 in Veterans Hospital.

A 1935 graduate of the Indiana University School of Medicine, Dr. Caplin interned at the old Indianapolis City Hospital. In addition to maintaining a general practice in Indianapolis, Dr. Caplin had been on the staff of state and veterans hospitals until forced to retire because of ill health a number of years ago.

During World War II Dr. Caplin served with the Army Medical Corps.

He was a member of the American Psychiatric Association, International Psychoanalytic Institute, the Marion County Medical Society and the American Medical Association.

David R. Clutter, M.D.

Dr. David R. Clutter, Indianapolis, died in Community Hospital July 29 as the result of an auto accident. He was 33. He had been in family practice in Indianapolis for a number of years but left that practice two weeks before his death to join the emergency room staff of Union Hospital, Terre Haute.

He received his M.D. degree from the Indiana University School of Medicine in 1971 and had taken a family practice residency at Methodist Hospital following his internship at the I.U. Medical Center.

A member of the Marion County Medical Society, Dr. Clutter was also a member of the American Medical Association.

William R. Dutchman, M.D.

Dr. William Rupert Dutchman, Muncie anesthesiologist, was killed in an auto accident Aug. 7 in Muncie. He was 54.

He was a 1948 graduate of Case Western Reserve University School of Medicine and then was an intern at Wilkes Barre General Hospital and a resident at Louisville General Hospital. Previous to moving to Muncie in 1964, where he was on the staff of Ball Memorial Hospital, Dr. Dutchman practiced in Evansville.

During World War II Dr. Dutchman served with the U.S. Army; he served with the Air Force Medical Corps during the Korean conflict.

Dr. Dutchman was elected to membership in 1957 and, in addition to his membership in the Delaware-Blackford County Medical Society, belonged to the American Medical Association.

Dan T. Miller, M.D.

Dr. Dan Tucker Miller, formerly of Fowler, died in Barnes Hospital at St. Louis on July 28. He was 91.

Dr. Miller was in general practice at Terre Haute from 1909 until 1927, when he moved to St. Louis, where he resided until 1952. In 1952 he moved to Fowler and was in general practice there until 1961, when he retired.

He was a graduate of the University of Pennsylvania Medical School and had served with the U.S. armed forces.

A past president of the Benton County Medical Society, Dr. Miller was a member of the American Medical Association. He was a Senior Member of the Indiana State Medical Association and became a member of its 50-Year Club in 1959.

Paul E. Strueh, M.D.

Dr. Paul Edward Strueh, Evansville otolaryngologist since 1951, died at Deaconess Hospital Aug. 29. He was 57.

He graduated from the University of Chicago School of Medicine in 1945, served his internship at the Presbyterian Hospital in Chicago and, following World War II, was a resident at Hines Veterans Hospital, the Eye and Ear Infirmary at Cook County Hospital and the Research and Education Hospital in Chicago.

From 1946 to 1948 Dr. Strueh served with the U.S. Army on ships in the Pacific area.

A Fellow of the American Academy of Otolaryngology and Ophthalmology, Dr. Strueh was also a diplomate of the American Board of Otolaryngology. He was a member of the Vanderburgh County Medical Society and the American Medical Association.

Everett W. Williams, M.D.

Dr. Everett Wendell Williams, 71, retired Columbus general practitioner and psychiatrist, died Sept. 3 at Bartholomew County Hospital.

He graduated from the Indiana University School of Medicine in 1930 after obtaining a degree in theology from Miami University, Oxford, Ohio. He interned at the old Indianapolis City Hospital and opened his office in Columbus in 1931, practicing in the same office until his retirement in June 1973.

Dr. Williams was instrumental in establishing the Bartholomew County Mental Health program and was an honorary lifetime member of the American Cancer Society. He served more than 20 years on the Bartholomew County Selective Service Board, following service with the U.S. Army during the second World War. He served as chief of staff in the neuropsychiatry department at Fort Knox, Ky.

A past president of the Bartholomew-Brown County Medical Society, Dr. Williams was also a member of the American Medical Association. In 1976 he was elected to Senior Membership in the ISMA. He was a lifetime member of the American Psychiatric Association.



NEWS NOTES

Hospital Medical Staffs Elect

Deaconess Hospital, Evansville—Dr. Edward L. Brundick, president; Dr. L. Ray Stewart, president-elect; Dr. Herman F. Rusche, secretary-treasurer. Drs. Jerry D. Becker, Kenneth L. Nachtnebel and Stewart P. Smith were elected to two-year terms on the executive council, and J. Ronald Waddell to a one-year term.

Gary Methodist Hospital—Dr. Douge Barthelemy, president; Dr. R. J. Doherty, president-elect; Dr. Felipe Chua, secretary; Dr. Randall Morgan, treasurer, and Dr. Leo Roth, delegate-at-large.

Welborn Baptist Hospital, Eansville—Dr. Alfred P. Lessure, president; Dr. Larry Beisel, president-elect; Dr. Marshall Miller, secretary-treasurer. Executive Committee members are: Drs. Jack Williams, Gregg Sheehan, Conn Healy, William Vincent, Ted Pavlick, Leon Stoller, Ali Akin and Ben Harned.

Bedford Medical Center, Bedford—Dr. Ross Wright, chief-of-staff; Dr. Abdolaziz Ardalan, chief-of-staff-elect; Dr. Richard Huber, secretary-treasurer. Dr. Wallace Johnson is immediate past chief-of-staff.

Morgan County Memorial Hospital, Martinsville—Dr. Stephen L. Hardin, chief-of-staff; Dr. George J. Ostheimer, secretary.

Community Hospital, Anderson—Dr. John Jones, president; Dr. Robert McCurdy, vice president; Dr. William VanNess II, secretary-treasurer; Dr. Donald Bixler, chief of staff.

New Edition of Merck Manual Available

The 13th edition of "The Merck Manual" has just been released. A complete volume for diagnosis and treatment of practically all diseases. Merck Sharp & Dohme Research Laboratories have published this book on a nonprofit basis since 1899. It may be purchased from medical book dealers or from Merck at P.O. Box 2000, Rahway, N.J. 07065.

Package on Hospital Fire Safety Includes Slides, Tape, Workbooks

"Firesafety in Hospitals," a new teaching package, based on a case study of a tragic hospital fire with eight fatalities, may be ordered from the National Fire Protection Association, 470 Atlantic Ave., Boston 02210, at a cost of \$65. The package consists of 35 mm slides (79 in all), a cassette tape, an instructor's guide and 10 student workbooks. It outlines firesafe operations in all hospital areas.

New Pamphlet on Cataracts

Public Affairs Pamphlet #545 is on "Cataracts and Their Treatment." It is written for laymen to explain what a cataract is, how it develops, its effects, and its treatment. The illustrated 24-page publication may be obtained at 50 cents per copy by writing to 381 Park Avenue South, New York City 10016. Quantity discounts are available.

Dr. McAtee Honored for 25 Years As Madison Hospital Superintendent

Dr. Ott McAtee was the honor guest at a luncheon held at Madison on Aug. 17 marking his 25th year as superintendent of Madison State Hospital. Addressing the luncheon guests, Governor Otis R. Bowen said: "Those 25 years have been years of dedicated and selfless service, and mental health leadership of an uncommon caliber."

Speakers Bureau on Urinary Tract Includes 88 Specialists, Teachers

Eaton Laboratories has organized a speakers bureau on the urinary tract. The roster of speakers is made up of 88 specialists, teachers and professors of urology, pediatric urology, obstetrics/gynecology and internal medicine. Full information may be obtained from Eaton representatives or by writing Eaton Professional Services Department, Norwich, NY 13815.

Indiana University Appoints Dr. Loh

The Board of Trustees of Indiana University has appointed Dr. Wei-Ping Loh, Gary, clinical professor of pathology at the University's Northwest campus. Dr. Loh has served as chief pathologist and director of laboratories at the Gary Methodist Hospital for the past 16 years.

President-Elect of the American College of International Physicians, Dr. Loh has served as president of the Indiana Association of Pathologists, the American Chinese Medical Society and the Asian-American Medical Society.

Governor Names Dr. Smith to Board

Dr. Fred Smith, Tell City, was recently appointed to the State Pesticide Review Board by Governor Otis R. Bowen.



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Continuing Medical Education

The following Indiana physicians are recent recipients of the AMA's Physicians Recognition Award. This award is official documentation of CME hours earned and is acceptable proof, in most states requiring CME in re-registration, that the mandatory hours of CME have been accomplished.

Amador A. Acosta, Gary
Dolores G. Adeva, Indianapolis
Kenneth A. Black, Valparaiso
David R. Cannon, New Albany
Saverio Caputi, Indianapolis
Charles M. Clark, Indianapolis
Alfred J. Dainko, East Chicago
Bruno De Palma, Lawrenceburg
Raymond W. Gize, Fort Wayne
Charles W. Hamm, Indianapolis
Stephen L. Hardin, Martinsville
Drew A. Kovach, Argo
Eugene Leman, Merrillville
Ora L. Marks, East Chicago
Carl D. Martz, Indianapolis
Geo. Elliott McCord, Indianapolis
Jason Y S Park, Terre Haute

William J. Pierce, Munster
Susan K. Pyle, Union City
Mohammad A. Rahmany, Griffith
Thomas J. Rusche, Evansville
James P. Sidell, New Haven
Philip L. Smith, Fort Wayne
Philip A. Szanto, Munster
Charles R. Thomas, Indianapolis
John D. Twenty, Indianapolis
Eugene D. Van Hove, Indianapolis
Theodore M. Warner, Indianapolis
Benjamin A. Weinberg, Whiting
John H. Wilms, Lafayette

Hospitals Honor Governor Bowen

Governor Otis R. Bowen, M.D., was named by the Indiana Hospital Association to receive the 1977 Indiana "Award of Merit" of the Tri-State Hospital Assembly.

"Governor Bowen has worked to develop practical solutions where legislation could assist in health care delivery prob-

lems," David L. Johnson, executive director of Deaconess Hospital, Evansville, and 1977 chairman of the IHA, said. Mention was made not only of the landmark health legislation enacted since Dr. Bowen was elected Governor in 1972 but of his 14 year of leadership in the Indiana House of Representatives, six years as its Speaker.

I.U. Receives Diabetes Research Grant

Indiana University School of Medicine has a grant of about \$1.4 million for establishment and operation of a Diabetes Research and Training Center, one of five such centers in the U.S. Principal investigator will be Dr. Charles M. Clark, Jr. The Center's three-fold function will be to: Provide community service to bring the latest treatment to diabetic patients, Research the prevention and treatment of diabetes, and Teach the best methods of diabetic health care to teams of health professionals. This is the ninth specialized center at I.U. The other centers are concerned with hypertension, genetics, cardiovascular diseases, general clinical research, health care research, basic cancer research, arthritis and psychiatric research.

Three Learning Modules Offered

"Learning Modules for Continuing Education" is the title of a brochure published by the 3-M Company, to announce three learning modules which are available to medical professionals. "Care and Prevention of Pressure Sores," "Cardiac Monitoring and Artifact Prevention," and "Surgical Taping Techniques" are the subjects. A free copy of the brochure may be obtained by writing 3M Company, P.O. Box 33686, St. Paul, MN, 55133.

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COULD THEY BE IMPROVED? ☐ YES ☐ NO







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 3. Because audits of quality of care, required in hospitals, are being increasingly applied in ambulatory care.

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30 Years of Service Recognized

Dr. Vactor O. Connell, Bourbon, was the guest of honor at a recent ceremony commemorating his 30 years of service to the community. Following his graduation from the Indiana University School of Medicine in 1942, Dr. Connell interned and was a resident at Baltimore Marine Hospital and Maryland University Hospital, then served with the U. S. Navy in the Philippines. A year at St. Louis Marine Hospital was followed by a tour of duty at the Marine Hospital in Mobile and a few months of practice in Mrs. Connell's hometown, Fulton, before setting up his practice in Bourbon in 1947.

Physicians Attain Certification

The Journal has learned of the certification of a number of Hoosier physicians by various medical specialty boards:

Dr. Donald A. Dian, Bluffton, has been certified by the American Board of Pediatrics.

The American Board of Surgery has announced that **Dr. Yng-Cherng Lin, Warsaw**, has successfully completed the certifying examination taken recently.

Dr. Chong Kim, Evansville, has received notice of his certification by the American Board of Anesthesiology.

Andreans Name Dr. Scully Man of Year

The Andrean Foundation named **Dr. John T. Scully, Merrillville**, "Man of the Year" recently. He served as co-chairman of the Foundation's successful fund-raising campaign for Andrean High School.

Serves on Boughman Memorial Heart Fund

Dr. Marvin N. Golper, Kokomo, has been reelected a trustee of the Dr. Joe Boughman Memorial Heart Fund, which was

established in 1967 following the death of **Dr. Boughman, Kokomo** physician. Contributions are used to assist the cardiac care wing of St. Joseph Memorial Hospital, Kokomo.

Honored for Service at Clinic

Dr. Jury B. Loving, New Goshen, was honored at a recent party for his 34 years of service at the Well Child Clinic.

Dr. Betty Dukes Awarded MH Bell

At the recent annual meeting of the Indiana Mental Health Association, **Dr. Betty Dukes, Sullivan**, long-time member of the Association's board, was awarded the MH Bell for her outstanding service over the years.

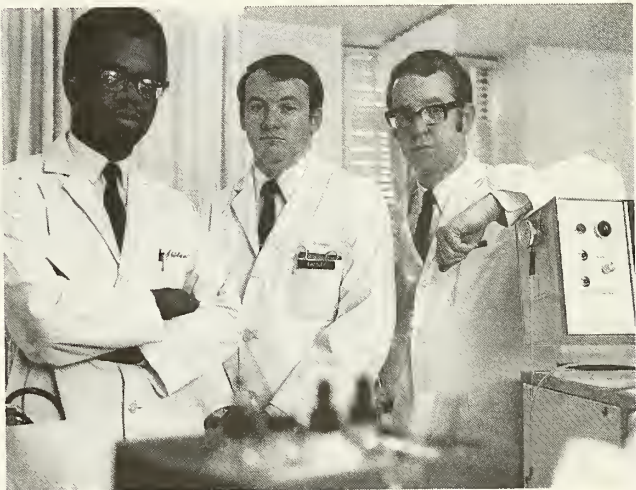
Dr. Weisenberger AOMA Fellow

Dr. B. L. Weisenberger, Columbus, medical director of the Columbus operations of Cummins Engine Co., was awarded Fellowship in the American Occupational Medical Association recently. The award was made in ceremonies held during the organization's 62nd annual meeting in Boston.

Reid Hospital Honors Eight Doctors

Eight Richmond area physicians were honored at the fourth annual appreciation dinner of Reid Memorial Hospital. **Dr. Joseph Zore**, chief of the medical staff, presented plaques to physicians for long service. Honored for 30 years were **Drs. James Logan, Charles Sage, Morris Snyder and Charles Kem**. **Drs. Frank Adney, Charles Loomis and Glen Ramsdell** received awards for 25 years and **Dr. Ray Weitemler** was cited for 20 years of service.

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NEWS NOTES

Continued

American College of Surgeons Inducts A Number of Hoosiers

Among those inducted into Fellowship by the American College of Surgeons within the past year have been a number of Indiana doctors:

Dr. Arthur N. Larson, Huntington; **Dr. B. Richard Goldburg**, Marion; **Dr. John E. Read**, Chesterton; **Dr. Thomas E. Bailey**, Linton; **Dr. V. S. Tumiluri**, Indianapolis; **Dr. E. C. Kho**, Scottsburg.

Lawyers Honor Dr. Wallace Bash

The Allen County Bar Association presented its Liberty Bell Award to **Dr. Wallace E. Bash**, Fort Wayne pediatrician, at the 1977 Law Day luncheon. Dr. Bash has been the U. S. jury commissioner for northern Indiana for 14 years and in that position "he has reflected the highest imaginable dedication by a lay person to our system of justice," according to the citation that accompanied the award.

Elected to Society of Scholars

Dr. K. K. Chen, Indianapolis, has been named to the Society of Scholars at Johns Hopkins University. The society honors only postdoctoral fellows at John Hopkins who have gained distinction in their fields of academic or professional interest. Dr. Chen is professor emeritus of pharmacology at the Indiana University Medical School and former director of pharmacological research at Eli Lilly and Company.

Physicians Elected to Fellowship

Dr. Patricia I. Bader, Bluffton, has been elected to Fellowship in the American Academy of Pediatrics.

Drs. Robert E. Jensen and John R. Thomas, Fort Wayne,

have been elected to Fellowship in the American Society for Head and Neck Surgery.

Describes Training for Boston Marathon

Dr. Gary P. Dillon, Fort Wayne, spoke to members of the Columbia City Rotary Club recently about how runners prepare for the Boston Marathon and of his experience as a runner in the most famous of America's marathon races.

Dr. Miller Named Good Neighbor

Recognizing nearly a half century of service to the Hagerstown community, the "Good Friend and Neighbor" plaque was awarded to **Dr. William A. Miller** at the community's 18th annual Rural-Urban Banquet recently. A 1927 graduate of the Indiana University School of Medicine, Dr. Miller began his practice in Hagerstown in 1928. A long-distance telephone call from Hoagy Carmichael, who was on the Bloomington campus at the same time as Dr. Miller, was also a surprise for the honor guest.

Philharmonic Elects Dr. Welborn

Dr. Mell B. Welborn, Jr., Evansville, was elected president of the Evansville Philharmonic Orchestral Corporation for 1977-1978 at the board's annual meeting recently.

Dr. Robert Ziss, also of Evansville, was elected to the Philharmonic board.

Appointed to Airport Authority

Dr. John Hildebrand, South Bend, has been appointed to membership on the St. Joseph County Airport Authority. He is a veteran member of the "Flying Physicians" and also serves as an examiner for the Federal Aviation Administration.

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Doctors Retire from Active Practice

Dr. William S. Dininger, Winchester general practitioner, retired from active practice on March 31. He opened his office in Winchester in 1926 and served one term as Randolph County Health Officer.

Dr. Leo Kenneth Cooper, Gary, retired recently after 37 years as an orthopedic surgeon. However, he has taken a part-time position on the staff of St. Mary Hospital, Gary, where he will be medical director of a newly established in-patient alcoholism program.

Dr. L. A. Malone, Terre Haute radiologist, retired recently.

Dr. Wemple Dodds, Crawfordsville, associated with the radiology department of Culver Hospital since 1929, retired in April.

Retirement of a number of other Hoosier physicians has taken place without mention in *The Journal*, through an oversight. **Dr. Orval J. Miller**, Fort Wayne, retired Dec. 31; **Dr. William B. McWilliams**, Liberty, retired last October; **Dr. Paul Wilson**, Logansport, retired in February; **Dr. J. Frank Stewart**, Vincennes, closed his private practice Dec. 31 and retired as director of Hillcrest Hospital, and **Dr. Marvin Marquardt**, Goshen, retired Jan. 31.

Dr. Seibel Receives Leadership Award

Dr. Robert M. Seibel, Nashville, was presented the physician leadership award of the Indiana Public Health Association when the group held its 31st annual convention recently.

Named to Football Hall of Fame

Dr. Joseph E. Kopcha, Gary obstetrician, was inducted July 29 into the Indiana Football Hall of Fame. His football career extended through Whiting High School, Chattanooga University, where he received All American and All Southern Conference honors, coaching at Alabama University, and a pro career with the Chicago Bears during their heyday, 1929 to 1934. According to the *Lake County Medical Society News* for September, it was Dr. Kopcha's pro football income that enabled him to study at Rush Medical College and obtain his M.D. degree.

Rhinological Society Elects Dr. Sputh

Dr. Carl B. Sputh, Indianapolis, was elected president of the International Rhinological Society at the group's annual meeting in Kansas City last month.

Fellow Rotarians Honor Dr. Hamilton

Dr. James Robert Hamilton, Mitchell, was honored by fellow Rotarians recently for his many years of service to the community as a general practitioner. He was made a Paul Harris Fellow of Rotary. The club's international student exchange program benefits from the funds contributed to the Rotary Foundation by a club in honor of a member.

Community Honors Retired Physicians

Six retired Columbus physicians were honored by the Bartholomew-Brown County Medical Society at a recent meeting. Among those receiving certificates of gratitude for their devotion to medicine in the community were: **Drs. Walter Able**, **Walter S. Fisher**, **Marvin E. Hawes**, **Richard Schmitt**, **Dorothy Teal** and **Everett W. Williams**.

Sports-Medicine Seminar at Valparaiso

Dr. Leslie Bodnar, South Bend, president of the American Association of Sports Medicine and team physician at Notre Dame, was one of the featured speakers at the all-day Sports-Medicine Symposium held July 23 at Valparaiso University. Porter County physicians who participated included **Drs. F. M. Sturdevant**, **John Poncher**, **A. J. Kobak** and **Robert Stoltz**.

NEW PROSTHETIC METHODS OPEN NEW DOORS

New doors have been opened to amputees — thanks to new prosthetic techniques. During the past few years many recent prosthetic developments now offer improved function for the amputee, as well as better appearance and increased comfort.

SILASTIC SILICONE MATERIAL - Silastic is useful in forming distal-bearing or total-contact pads that apply form-fitted pressure on the distal end of stumps. The density of this material may be varied to suit the individual requirements of each amputee.

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MUENSTER FITTING - Better control with less harness is achieved in this new method of fitting very short—below elbow stumps. The unusual socket shape utilized provides a more intimate fit assuring a more functional prosthesis.

For information on these developments, please write to:

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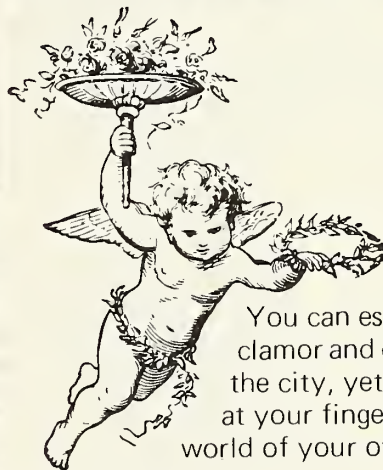
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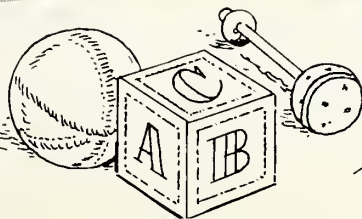
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Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium[®] (diazepam)^{IV}

2-mg, 5-mg, 10-mg scored tablets
**a prudent choice in psychic
tension and anxiety**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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MEDICAL

MUSEUM NOTES



The photograph reproduced on this page was given to the Museum by Dr. William Niles Wishard, Jr., who was a member of the Association's original Medical History Committee. The subject is Dr. Livingston Dunlap, who founded the hospital which is now named for Dr. Wishard's father.

Livingston Dunlap was born in Cherry Valley, N.Y., in 1799, and came to Indianapolis in 1821. He apparently had become a physician by way of the apprenticeship system, since he later obtained a medical degree from Transylvania University at Lexington, Ky.

Neither Kemper nor Stone, the usual biographical sources for 19th Century Hoosier physicians, give biographical data about Dr. Dunlap, although Kemper does describe Dr. Dunlap's activity with the Indiana State Medical Society. John Nowland (*Sketches of Prominent Citizens, Indianapolis*, Tilford and Carlin, 1877) gives this early account of Dr. Dunlap:

When he first arrived in this place (Indianapolis) he stopped at the house of Dr. Samuel G. Mitchell, who lived . . . where the State offices now stand . . . Not only the whole family with which he stayed were taken down with the chills and fever, but himself so bad he could neither render assistance to them, nor they to him. In this situation my father found them one day, when he called to see what he could do . . . My father at once proposed to take the doctor (Dunlap) home with him. . . . But how was he going to get him there? queried the

doctor—"Take you on my back" was the answer, which he did.

Dr. Livingston Dunlap served as the presiding officer when the Indiana State Medical Society was organized in 1849. ("Society" was changed to "Association" in 1904.) Also in 1849 he was elected professor of the theory and practice of medicine in the newly formed Indiana Central Medical College. From 1845 to 1849 he served as postmaster of Indianapolis, having been appointed by President Polk; during these same years he also served with Dr. John Evans and Dr. John Bobbs as a commissioner in the erection of the state's first mental hospital. In addition, he served

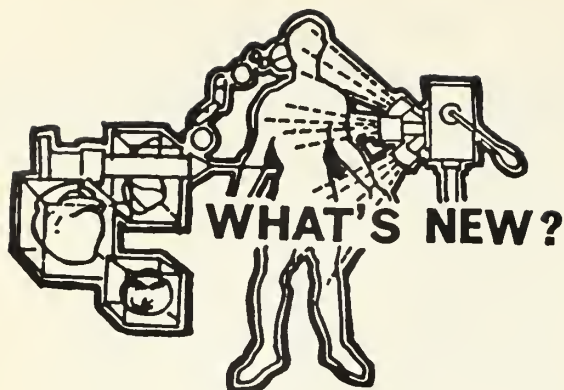
for a number of years (starting in 1830) as city councilman and in this capacity was the person primarily responsible for erecting the city's first hospital, now designated as the Wishard Memorial Hospital.

Dr. Dunlap was 63 when he died in 1862. Of his three surviving sons, one (John) was also a physician. Another, James, was an artist. James Dunlap is the subject of next month's page, for appreciation of which the interested reader is urged to save this reproduction of the photograph of Dr. Livingston Dunlap.

CHARLES A. BONSETT, M.D.
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Livingston Dunlap, M.D., 1799-1862



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Doubleday has released "Nothing to Fear: Coping with Phobias" by Fraser Kent. It is written for the information of the public on the theory that, because phobias are embarrassing and, therefore, not often discussed by their victims, general discussion by way of a good book and the realization that phobias are not uncommon, will aid in coping with and even diminishing the ailment. Price is \$7.95—216 pages.

* * *

Axiom Medical announces a new instrument, the first of its kind, for automatically applying tantalum ligating clips. The clips are fed to the distal tip in quick succession for rapid hemostasis. The magazine holds 15 clips, thus eliminating frequent passage of clip applicator from nurse to surgeon.

* * *

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* * *

McIntyre Lighting of San Leandro, Calif., announces the McIntyre Hand Held Examination Light for medical uses. The light will focus a color-corrected, even light on any part of the patient. It has a two-foot retractable cord which extends to 12 feet.

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JaBro Batteries, Inc. recently published a new six-page catalog featuring an expanded line of rechargeable and throw-away batteries. Included in this listing are batteries for medical instruments, incubators, defibrillators, pagers and other specialized equipment.

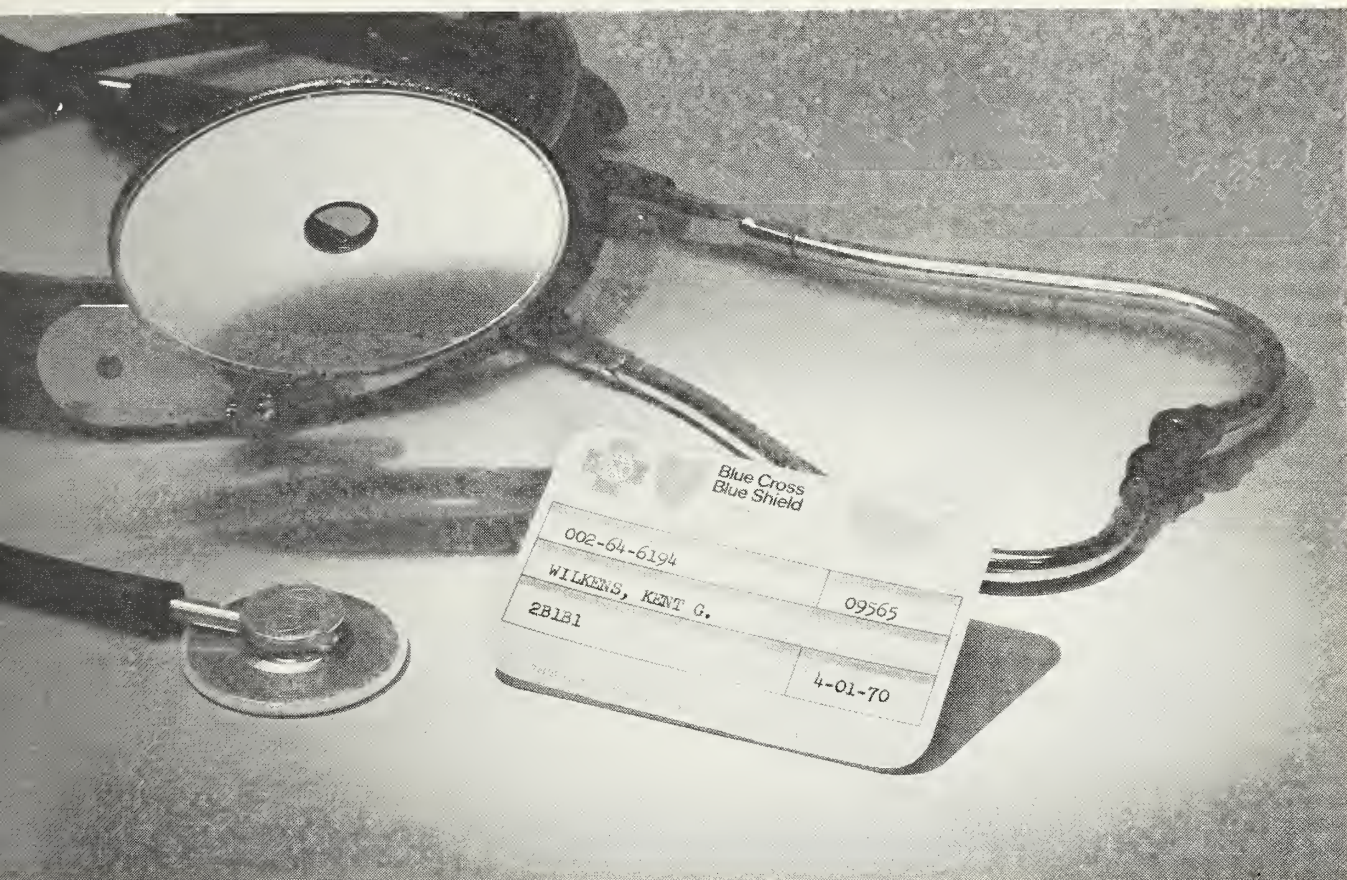
* * *

The Charles Press Publishers have issued the Third Edition of "Intensive Coronary Care" by Drs. Meltzer, Pinneo and Kitchell. More than 500,000 copies of the manual are fixtures in hospitals. Success of the book is due to the authors' premise that the nurse must assume a more demanding role in the care of coronary patients. Available in October. 294 pages—\$10.50.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

BURDENED HEAVILY WITH ADMINISTRATION ENERGY PROPOSALS and tax reform measures, the first session of the 95th Congress staggers toward adjournment with a number of important health bills still far from resolved.

Among these important health bills are: The Hospital Cost Containment Plan, the Health, Education, and Welfare appropriation, a sweeping overhaul of Federal Drug Administration procedures, Medicare and Medicaid amendments, new federal controls over clinical laboratories, aid for rural health clinics, guidelines for genetic research, easing required U.S. medical school admission of foreign medical graduates, postponing the proposed saccharin ban, amending the black lung and renal disease programs, expanded aid for maternal and child health care, continued higher pay for federal and military physicians and excuse from income tax of federal medical scholarship income.

HOWEVER, THE MEDICARE-MEDICAID ANTI-FRAUD AND ABUSE BILL has won overwhelming House approval on

the way to expected final passage this year. Stricken from the measure was a provision to guarantee medical records privacy.

The bill, cleared by a 362-5 vote, vaults Professional Standards Review Organizations (PSROs) into major monitoring bodies to detect fraud and abuse in federal health programs.

The legislation also directs HEW to develop ambulatory care review methodologies for PSRO use; directs HEW to require capable PSROs to undertake ambulatory care review within two years after designation as a PSRO; makes "competent" PSRO reviews of services conclusive for purposes of federal payment, if the PSRO has entered into a memorandum of understanding.

Fraud and abuse information detected by a PSRO would be provided to federal and state investigative agencies. Patient records in the PSRO would not, however, be subject to subpoena or discovery proceedings in a civil action.

Other provisions of the bill provide:

- **increased Medicare penalties by upgrading fraudulent acts from misdemeanors to felonies;
- **suspension from participation in Medicare and Medicaid for practitioners convicted of a criminal offense related to involvement in Medicare or Medicaid;
- **annual disclosure by Medicare and Medicaid institutional providers of the identity of any person with a 5% or more ownership in the institution;
- **authority for subpoenas for information and review of Social Security health programs.

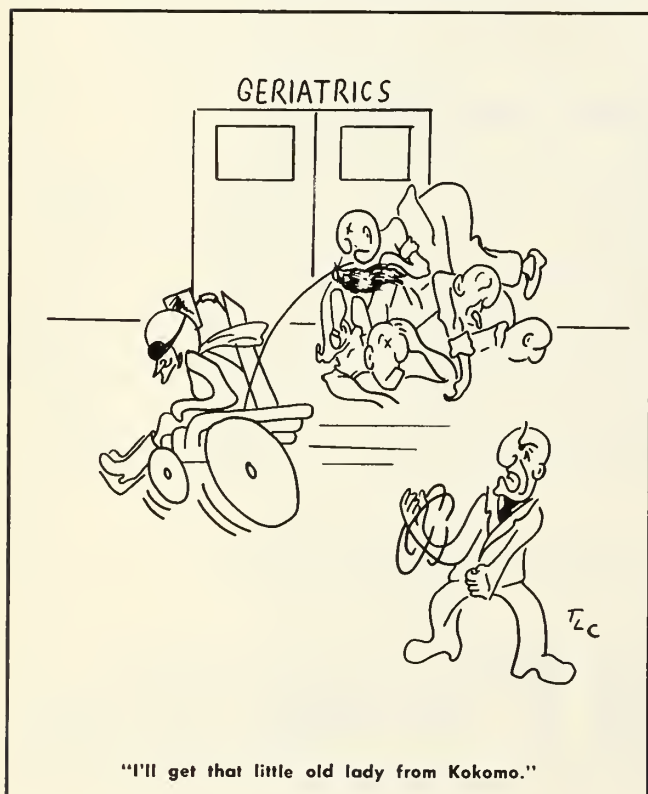
The bill, worked out jointly by the House Ways and Means and House Commerce Committees, also required HEW to establish uniform reporting systems for health services institutions.

HEARINGS EARLIER ON THE SENATE VERSION of the House-passed Medicare-Medicaid anti-fraud and abuse bill drew testimony from the AMA as to the importance of providing strong safeguards against the abuse of the confidentiality of patient records. Testifying before the Senate Finance Subcommittee on Health, Robert B. Hunter, M.D., chairman of the AMA Board of Trustees, said "inappropriate distribution of individual medical records adversely affects the individual's constitutionally protected right of privacy."

Dr. Hunter supported a provision approved by the House Commerce Committee that prohibits PSROs from disclosing to the government PSRO records on individual patients not covered by federal programs without their written consent.

Dr. Hunter said the success of the patient-physician relationship depends to a great extent on the willingness of the patient to discuss freely with his physician all subjects relating to individual health, no matter how personal or sensitive. "Should either party feel that this information, discussed pri-

Continued on page 860



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*National Disease & Therapeutic Index, Jan.-Dec., 1976. IMS America Ltd., Ambler, Pa. 1976.

†Amer. Med. Assn., Dept. of Drugs, A.M.A. Drug Evaluations, 2nd Edition, Publishing Sciences Group, Inc., Acton, Mass., 1973, pp. 482-3.

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vately, will become a matter of public record, the foundation of the patient-physician relationship would be irreparably harmed."

HEW HAS ISSUED DETAILED GUIDELINES for health planners that include a goal of fewer than four hospital beds per 1,000 population.

"The guidelines will help put brakes on construction of new hospital bed space and high-cost specialty services such as open-heart surgery and computerized x-ray scanning," said HEW Secretary Joseph Califano.

The proposals, which are not final, would immerse the federal government deeply into allocation of health resources in communities and regions across the nation.

Regional Health Systems Agencies, provided in the Health Planning Law and challenged in court by the American Medical Association, not only are told to aim for a four per 1,000 bed ratio, but in later years "will be required to indicate how they will reach a bed population ratio of 3.7 per 1,000," according to HEW.

The current national average is 4.4 beds per 1,000 population. The reductions proposed by HEW would eliminate some 100,000 beds of the present one million beds over the next seven years. The number of beds at present "is significantly in excess of what is actually needed . . . and contributes to the high cost of hospital care with little or no recognizable health benefits," said HEW.

The guidelines propose that there should be an average annual occupancy rate of at least 80 percent for all non-federal, short-term hospital beds except under extraordinary circumstances. Exceptions would include small rural hospitals and facilities in areas with large seasonal changes in population.

A spokesman for the American Hospital Association commented that the proposals were too detailed and would provide less flexibility for local planning agencies if Congress grants HEW the power to put them into effect.

However, three members of the Senate Human Resources Subcommittee on Health—Sens. Edward Kennedy (D-Mass.), Jacob Javits (R-N.Y.), and Richard Schweiker (R-PA)—wrote Secretary Califano that they were "pleased that HEW has 'bitten the bullet.'" The time has come, they said, "to set numerical standards."

If the recommendations were accomplished, HEW officials said, the nation would save more than \$2 billion annually. HEW pins its hopes for the guidelines on Congress approving a law giving the federal government more teeth over localities in enforcing and mandating standards. The planning law comes before Congress for extension and revision next year.

In addition to the number of beds and occupancy rate recommendations, here is what the proposed regs set forth:

****Obstetrical services:** there should be at least 2,000 deliveries annually in an obstetrical unit located in an area with a population of 100,000 or more and at least 500 deliveries in any unit located in an area with a smaller population.

"In view of declining birth rates and the mounting underutilization of obstetrical beds, obstetrical standards for the minimum number of deliveries and occupancy rates are designed to discourage unnecessary duplication and inappropriate proliferation of services, and to maintain quality of care," said HEW.

****Pediatric inpatient services:** there should be a minimum of 20 beds in a pediatric unit, except in rural areas.

Pediatric units should maintain average annual occupancy

rates related to the number of pediatric beds (exclusive of neonatal intensive care units) in the facility. For a facility with 20-39 pediatric beds, the average annual occupancy rate should be at least 65%; for a facility with 40-79 pediatric beds, the average annual occupancy rate should be at least 75%; for facilities with 80 or more pediatric beds, the average annual occupancy rate should be at least 80%.

****Neonatal intensive care units:** the total number of neonatal intensive care beds should not exceed four per thousand live births per year in a defined neonatal service area. A single neonatal intensive care unit should contain a minimum of 20 beds.

****Open-heart surgery:** There should be a minimum of 200 procedures performed annually in any institution in which open-heart surgery is performed. No new open heart units should be opened unless each existing or previously approved unit in the health service area (or areas) to be served is operating and is expected to continue to operate at a minimum of 350 open-heart surgery cases per year.

****Cardiac catheterization:** there should be a minimum of 300 procedures (intracardiac and/or coronary artery catheterization) performed annually in any adult cardiac catheterization unit plus a minimum of 150 cardiac catheterizations performed annually in any pediatric cardiac catheterization unit. No new cardiac catheterization units opened in any facility not performing open-heart surgery. No new adult cardiac catheterization units opened unless the projected number of studies per year is greater than 500.

****Radiation therapy:** a megavoltage radiation therapy unit should serve a population of at least 150,000 persons or at least 450 new cancer cases per year. No new megavoltage units opened unless each existing or approved megavoltage unit in the Health Service Area(s) is performing and is expected to continue to perform at least 7,500 treatments per year.

****Computed tomographic scanners:** computed tomography (head and body) should operate at a minimum of 2,500 patient procedures per year. There should be no CT scanners approved unless each existing or approved CT scanner in the service area is performing at a rate greater than 4,000 patient procedures per year.

****End-stage renal disease:** the health systems plan established by Health Systems Agencies should be consistent with standards and procedures contained in the HEW regulations governing conditions for coverage of suppliers of end-stage renal disease services.

EIGHT MONTHS AFTER PUBLICATION OF A BOTCHED LIST of physicians receiving substantial Medicare payments in 1975, the government has published a new list reworked from top to bottom. After a protest last spring from the AMA over the high error rate, HEW Secretary Califano apologized and promised release of a corrected list.

Last March, responding to requests from the news media, HEW printed the names and amounts received of 409 physicians and 1,750 groups that did more than 100,000 of Medicare business in 1975. The Freedom of Information Law compelled this disclosure, HEW said.

The AMA checked the original list and found, in a sizable sample, an error rate of more than 60%.

HEW officials have announced that next time they will list all physicians who received any Medicare payments at all in 1976. Estimated costs to the government of preparing this annual listing is from 700,000 to \$1 million at the start and some \$300,000 annually afterward. No estimates have been made of how much added cost would fall on the carriers who have prime responsibility for gathering such data.

"OPERATION COMMON SENSE" TO MAKE READABLE the 6,000 pages of HEW Department regulations has been launched by HEW Secretary Califano.

Along the way some provisions will be eliminated in the "top-to-bottom" overhaul that will take years, Califano said.

"Long complicated regulations, often taking years to issue, have too long been the hallmark of the federal government in general and this department in particular," Califano said. "The President has vigorously declared his desire to see shorter, clearer regulations issued in timely fashion. I am determined that this department lead the federal government in the direction charted by the President."

Forty-five pages of material were issued to the press to explain Operation Common Sense. In reply to a question about this from a reporter, Califano said with a smile that sometimes clarity isn't served by brevity.

THE GOVERNMENT HAS PROPOSED REGULATIONS to strengthen the Medicaid child health screening program (EPSDT).

The regulations set forth by the Health Care Financing Administration (HCFA) clarify and update existing provisions dealing with penalties for states that fail to comply and method used in carrying out the screening of children. One purpose is to give states greater flexibility in administering the plan.

HCFA said "states have a responsibility to provide scheduling assistance, transportation and follow-up services to eligibles in order to remove significant obstacles that program experience clearly indicates eligibles generally have in obtaining EPSDT services."

The regulation adds immunization to the screening package rather than as an item to be determined for treatment later.



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The Temperature in Normal Term Newborns in the First 12 Hours

C. B. KIM, M.D.
BENJAMIN A. RANCK, M.D.
EILEEN B. DEAN, R.N.
PATRICIA S. WALKER, R.N.

DURING recent years the importance of minimizing heat loss immediately after birth has been emphasized by many investigators. The newly born infant has difficulty maintaining temperature stability and practical methods of monitoring temperature should be sought. Also, special measures to conserve heat are to be taken. It must be stressed that the maintenance of an optimal thermal condition is one of the most important aspects of effective neonatal care.

Materials and Methods

The data in this study have been compiled from an analysis of 450 consecutive healthy term neonates (birth weight greater than 2,500 gm, gestation age over 38 weeks, Apgar scores 7 or greater at one minute and five minutes respectively) delivered at the Bartholomew County Hospital, Columbus, between Jan. 7, 1976 and June 25, 1976. The infant born by a Cesarean section, and the small-for-date infant were excluded from this study. Omitted also were those infants of mothers who had intrapartum complications such as toxemia, profuse

vaginal bleeding and significant fetal distress with a late deceleration curve.

Following delivery all infants were immediately placed on a warm bed with an overhead radiant heater and the first axillary temperature by IVAC thermometer was recorded. All infants received routine newborn care in the delivery room, including cord clamping, foot printing, eye prophylaxis and thorough drying. The mean time in the delivery room was 27.54 minutes.

The infants were transported to the nursery wrapped in warm bath blankets, where all were placed in open bassinets and covered with bath blankets. Two gooseneck lamps with 40-watt bulbs were placed approximately 25 cm above the lid of the bassinet and this was continued throughout the time of study. An additional axillary temperature was then recorded on admission to the nursery. Comparison was made between rectal and axillary temperature. Temperatures were taken at 30 minutes and hourly through five consecutive hours and again at 12 hours. The nursery and delivery room temperature (average 72.4 F and 72.2 F respectively) were recorded as well as relative humidity (average approximately 62%). The first bath was given to the infant when axillary tempera-

ture was stable at 97.7 F (36.45C). The blood glucose concentrations by Ames Eytone/Dextrostix system were determined on the cord blood ($60.92\text{mg}\% \pm 19.85$) and heel stick at admission to the nursery ($44.42\text{mg}\% \pm 18.73$).

Results

It is known that the temperature of the newborn infant falls immediately after birth. The rapid fall of temperature is mainly due to evaporation from its moist body. It has been documented that the deep body temperature may fall 2-3 C unless special methods to conserve heat are taken. Radiant warmers have been widely used in the delivery room to minimize loss of body heat in the first minutes after birth.

As shown in Table I, there was no significant drop in axillary temperature immediately after birth when infants were placed under warmers for immediate newborn care. Rectal and axillary temperatures taken at admission to the nursery were similar. (Table II) There were no remarkable changes in axillary temperature during the movement from delivery room to nursery. The utilization of axillary temperature was necessary to avoid trauma to the rectum. The first bath

From Kroot's Intermediate Care Nursery, Bartholomew County Hospital, Columbus, Indiana.

TABLE I. AXILLARY TEMPERATURE (C \pm SD)

At Delivery	At Admission to Nursery	1/2 Hour	1 Hour	2 Hours	3 Hours	4 Hours	5 Hours	12 Hours
36.42 \pm 0.72	36.32 \pm 0.62	35.94 \pm 0.60	36.14 \pm 0.58	36.34 \pm 0.52	36.46 \pm 0.46	36.49 \pm 0.38	36.51 \pm 0.37	36.86 \pm 0.82

TABLE II

	Rectal	Axillary
Temperature at Admission (C \pm SD) to Nursery	36.45 \pm 0.89	36.32 \pm 0.62

TABLE III

	Before Bath	After Bath
Axillary Temperature (C \pm SD)	36.36 \pm 0.45	35.47 \pm 0.33

was given after the axillary temperature was stabilized, and the median time at which the first bath was given after arrival at the nursery was 29.76 minutes. It ranged from two minutes to four hours six minutes. Seventy-six percent of baths were given within the first 30 minutes after admission to the nursery and the only significant drop in axillary temperature was observed following bath. (Table III)

Hypoglycemia (glucose concentration less than 30mg%), all asymptomatic, occurred in 47 infants (10.44%) at admission to the nursery. Their mean temperature (36.19 C \pm 0.84) was similar to that of the other infants in this study (36.33C \pm 0.78).

Comments

1. The temperature of the body may be measured at different locations. No single site gives an accurate representation of the deep body temperature. Axillary temperatures may be falsely high because of large deposits of heated brown fat in the axillary area. In most instances rectal temperature is suf-

ficiently accurate. However, the normal rectal temperature does not reflect the absolute thermal condition, and frequent measurement of temperature rectally is not advisable in the newborn infant. Our data reveal that the measurement of axillary temperature corresponds well with rectal temperature in the neonate.

2. At birth substantial amounts of heat are immediately lost to the cold environment by evaporation. This mode of heat loss is readily eliminated when the baby is dried and placed on an open radiant warmer.

3. Bathing during the first hour after birth appears to decrease body temperature significantly despite previous stabilization of temperature. Our study would suggest that delaying the bath would minimize instability of temperature.

Acknowledgments

The authors are grateful to Dr. Edwin Gresham of Indiana University School of Medicine for his kind criticism and to the staff of the nursery and the delivery room of Bartholomew County Hospital

for their dedicated assistance. ◀

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Hepatitis Antigen — Antibody Tests and Their Clinical Significance

PHILIP A. CHRISTIANSEN, M.D.
Indianapolis



FOR most of their practicing years physicians have only been able to classify acute viral hepatitis into two general categories—infectious (IH) and serum (SH). Even this division was based on the time interval since any known exposure and/or recent blood transfusion. No specific means existed (including liver biopsy) to make a specific diagnosis. Therefore, it was impossible to accurately assess the natural history, sequelae or prevention. In addition to these difficulties in differentiating IH from SH, their separation from other causes of acute hepatitis such as drugs, cytomegalic virus and infectious mononucleosis (Epstein Barr virus) was sometimes a problem. Many of the preceding quandaries are now resolved and current work is being directed to solving the rest.

Thirteen years ago the world of hepatitis started turning around. The precipitous change was started with Blumberg's discovery of the Australian antigen.¹ Its importance to Medicine has been emphasized by a Nobel Prize for Dr. Blumberg.

The Australian antigen (now HB_s Ag) has led to (1) the specific diagnosis of acute Type B viral hepatitis; (2) substantial decrease—at least 25%—of the most dangerous type of viral hepatitis, that is, post-transfusion; (3) help in suspecting chronic hepatitis; (4) a means of accomplishing active immunization and establishing the

efficacy of the types of passive immunization; (5) enormous impetus to the search for the identification of Type A antigen (now accomplished). The latter, with HB_s Ag, has led to the categorization of a third type of acute viral hepatitis, i.e., Type C or non-A, non-B.²

Terminology

Most new medical information based on technology can be expected to temporarily suffer from confusion of terms. Hence, its usefulness to busy practitioners is often delayed or reduced. The new era of hepatitis is a clear case in point. (Indeed, it is the motivation to write this article.) Besides the problem with the sensitivity of the original test method (agar gel—highly specific but rather low sensitivity) which led to “false” negatives, the confusion of terminology is due both to the extreme care of earlier investigators in assigning disease specificity to the tests and to the rapid development of the field itself.

Table 1 defines the current terminology for the three types of acute viral hepatitis, including their synonyms. Non-A, non-B hepatitis was described in 1975 by Feinstone, et al. (who also identified Type A antigen in 1973³) and is reviewed by Blumberg⁴ in July 1977 *Annals of Internal Medicine*. That issue also has three other articles on non-

A, non-B hepatitis.^{5,6,7} All have many current references pertinent to the whole subject of this paper.

The terminology for the hepatitis antigens and antibodies is listed in Table 2. With the establishment of HA Ag it is evident that the most commonly used term for the clinically available antigen in Hepatitis B—that is, HAA, can no longer be used and the correct designation HB_s Ag is essential.

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Clinical Significance

The ensuing discussion follows the order of Table 2 and includes various points tabulated in Table 3 and/or illustrated in Figures 1A and B. The designations "carrier" and "chronic hepatitis" are not necessarily synonymous. Despite chronic positivity of a test (as in **HB_s Ag** below) some patients may have no symptomatic, biochemical or histologic evidence of disease. Nevertheless, all chronically positive **HB_s Ag** patients need appropriate evaluation for chronic hepatitis, because the more serious of those, i.e., chronic active hepatitis, is successfully treated (with steroids).

VIRUS A—HA Ag is found in the stool of patients preceding and at least early in the acute clinical period of Hepatitis A infections. It may remain positive throughout the period of clinical jaundice. There are no recognized chronic carriers. **HA Ag** has not been convincingly demonstrated in blood, though presumably it is there even if transiently and/or in low titers.

Anti-HA Ag—Positivity to this test starts early in the acute phase of Hepatitis A disease. **HA Ag** is probably still found in the stool because the antibody titer starts to rise rapidly with a peak two weeks after the acute hepatitis syndrome. It remains high for several weeks

TABLE 1 TERMINOLOGY OF VIRAL HEPATITIS

Virus A (HAV)	
Synonyms:	Infectious Hepatitis (IH), short incubation hep., MS-1, epidemic Jaundice
Virus B (HBV)	
Synonyms:	serum hepatitis (SH), posttransfusion hep., long incubation hep., MS-2, Antigen positive hep.
(Type C) non-A, non-B	
This form is now clearly separate from A and B. It is probably similar in most of its respects to Virus B except that it has no immunologic markers and the status of prophylaxis is unknown. It accounts for 50% of hepatitis following blood transfusions.	

TABLE 2 VIRAL HEPATITIS, ANTIGENS AND ANTIBODIES

Type A Hepatitis	
Antigen	HA Ag: Hepatitis A Antigen
Antibody	anti—HA Ag: Antibody to HA Ag
Type B Hepatitis	
Antigen	HB_s Ag: Hepatitis B surface antigen
	Synonyms. Au Ag —Australian antigen, HAA —Hepatitis Associated Ag., HB Ag —Hepatitis B Ag, SH Ag —Serum Hep. antigen
	HB_c Ag: Hepatitis B core Antigen
Subtype Antigens	a, d or y, w or r
Antibodies	anti-HB_s Ag: antibody to HB_s Ag
	anti-HB_c Ag: antibody to HB_c Ag
Associated Systems	e-Ag: e-antigen
	anti-e: Antibody to e-antigen
(Type C) non-A, non-B	
No immunologic markers	

TABLE 3 HEPATITIS ANTIGEN AND ANTIBODIES

Source, Frequency and Length of Positivity

	Source	Frequency (Adults)	Length of Positivity
VIRUS A			
HA Ag	Feces (Blood)	No carriers	2-4 weeks (1 week after onset of acute clin. stage)
anti HA Ag	Blood	U.S.—30%: increase with age and in lower socioeconomic group	Longer than 10 years
VIRUS B			
HB_s Ag	Blood, also saliva and semen	Carriers: U.S.: 0.2% Africa, Asia: 15%	2-3 mos. (1 mo. before and thru the acute clinical stage)
anti HB_s Ag	Blood	U.S.—15%; Foreign—variably much higher	Indefinitely long but not necessarily for all patients
HB_c Ag	Liver, blood		
Anti HB_c Ag	Blood		Usually 48 mos. or longer

and probably remains positive for at least 10 years.

The diagnosis of current or very recent Hepatitis A infection can be confirmed with the demonstration of a rising titer of the antibody. It is important, therefore, to start sampling at the earliest clinical suspicion. However, a single positivity, particularly after the acute clinical state, does not establish that the recent acute episode was due to Hepatitis A, because 30% or more of the U.S. population is positive to anti-HA Ag.

Individuals with anti-HA Ag have immunity to reinfection with HAV.

VIRUS B—Electron microscopy has shown Dane particles in both the liver and serum of patients with Hepatitis B. It is likely that they are the HB virus and it may be that HB_s Ag is the outer coat of the virus and HB_c Ag is the core.

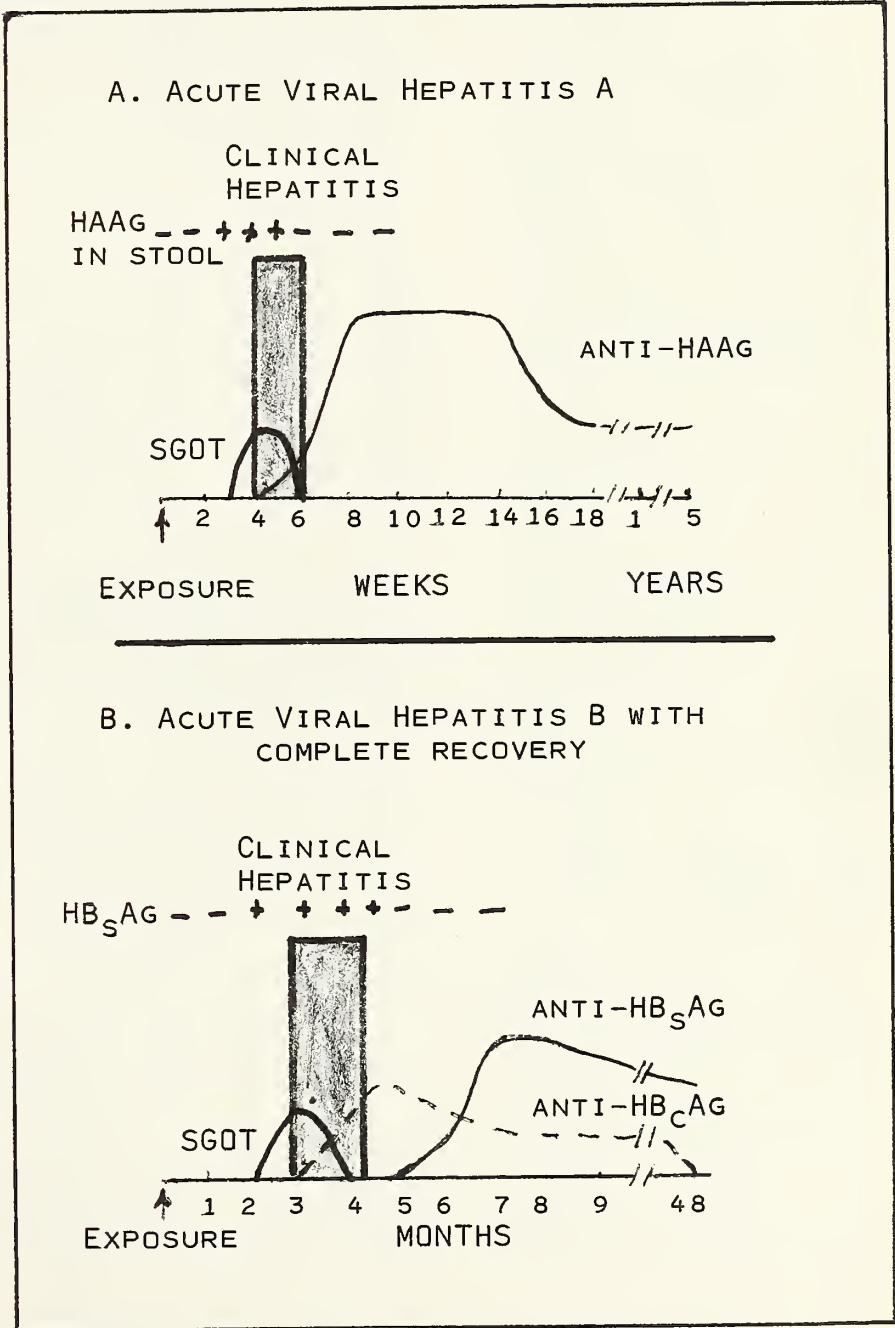
HB_s Ag—HB_s Ag positive sera in a patient with acute hepatitis is diagnostic for Type B hepatitis. The test is positive for a month prior to the overt symptoms and usually remains so throughout the acute stage. (Table 3 and Fig. 1B) The test should be ordered as early as possible to lessen the chance for a "false negative" in those patients who become so earlier than in the average case. An alternative possibility is that the patient has chronic hepatitis (either persistent or active) and the current illness is the first apparent manifestation of chronic disease. It is very important to follow the originally "acute hepatitis" patient with repeat HB_s Ag tests, e.g., every 2-3 weeks until they become negative.

There are a number of different situations which are encountered in practice and, while judgment is certainly required, the following general guidelines are offered for patients with persistently positive HB_s Ag and time of evaluation (usually including percutaneous liver biopsy) for chronic hepatitis. Overall, the more persistent of clinical symptoms and laboratory abnormality, the earlier the evaluation:

- (1) Clinical symptoms persist, liver tests (e.g., SGOT greater than 100) remain abnormal—2-3 months;
- (2) Clinical symptoms resolve, liver tests remain abnormal—3 months;
- (3) Clinical symptoms resolve, liver tests normal or near normal—4 months;

- (4) Originally asymptomatic, abnormal liver tests—3 months;
 - (5) Originally asymptomatic, liver tests normal—4 months.
- Patients with HB_s Ag positive blood have to be considered capable of transmitting Hepatitis B via their blood (50% of such transfusion recipients get hepatitis) or needles used on them. Screening

FIGURE 1 - TYPICAL COURSE OF VIRAL HEPATITIS*



*After Aach, Reference No. 2.

these patients for their infectiousness may be accomplished by the E-antigen system (see below).

The problem of restrictions on health personnel who are HB_s Ag carriers may not have been totally resolved. However, there is strong evidence that these individuals do not represent any specific risk to their clientele.

HB_e Ag—This antigen is synthesized in the nucleus of infected hepatocytes. With special preparation of samples it can be found in the blood and it probably implies virus replication.

Sub Type Antigens—This system is of importance in tracing epidemics and comparing various types of Hepatitis B infections in various geographic locations. It is not very important in the usual clinical setting. The subtypes are not related to severity, chronicity, etc.⁸

Anti-HB_s Ag—This antibody occurs after the disappearance of HB_s Ag from the blood and during convalescence from Hepatitis B infection (Figure 1B). Although the length of its remaining positive is unknown, it may be indefinitely long for some/most individuals. The finding of antibody without a previously identifiable episode of acute hepatitis, nonetheless, establishes the previous presence of the disease. Its positivity, on single testing, following a fairly recent episode of acute hepatitis does not necessarily establish that that episode was a Hepatitis B infection because of the moderately high (15%) prevalence in the U.S. population (See Table 3).

On the other hand, a rising titer of anti-HB_s Ag sampling within the two months following an acute hepatitis episode is indicative of an immediate past HBV infection.

Failure of the appearance of Anti-HB_s Ag (along with a persistence of high HB_e Ag) with continuing positivity to HB_s Ag is another indication (see HB_s Ag discussion previously) of possible chronic hepatitis (or carrier state).

As with anti-HA Ag in HAV, the presence of anti-HB_s Ag indicates

immunity to further HBV infection.

Anti-HB_e Ag — As shown in Figure 1B, this antibody starts rising with the acute clinical stage of Hepatitis B. It peaks at the end of the clinical illness and probably gradually decreases to disappearance in 48 months or longer.

Associated Systems

The e-antigen/antibody system has had limited investigation. It is found almost exclusively in patients with prolonged HB_s Ag activity. Fifty per cent of asymptomatic patients (with normal liver tests and biopsies) have anti-e, while the e-antigen was positive in more than half of chronic HB_s Ag patients with abnormal liver biopsies showing liver disease.

Other studies show that the infectivity of HB_s Ag carriers who have anti-e in their sera was different than in those who did not. Transfused blood that was HB_s Ag and anti-e positive did not result in post-transfusion hepatitis.⁹ Similar implications have been found in HB_s Ag positive pregnant women and the subsequent HB_s Ag positivity of their newborns.

These early results hold strong promise for not only identifying the HB_s Ag positive patients who remain infectious but may allow early identification of those who may develop chronic disease.

While all these different antigens and antibodies are adding tremendously to our understanding of the clinical problems in viral hepatitis, how available are these various immunologic markers? Which ones are currently available, or soon will be, to the practicing physician? HB_s Ag is universally available in U.S. hospitals. Anti-HB_s Ag is performed in most large hospitals and commercial laboratories. It is expected that anti-HA Ag will be available within one year at larger institutions and commercial labs. Current methods of isolating HA Ag do not promise early "routine" use, while both HB_e Ag and anti-HB_e Ag involve only moderately sophisticated technology. The e-

antigen/antibody system involves very simple technology (agar gel) and could be easily assayed in every hospital laboratory with adequate antigen supply.

Features of Viral Hepatitis—Table 4

The new information resulting from the application of antigen/antibody tests has not only allowed for specific diagnosis of both Virus A and B hepatitis but in other ways confirmed, modified or completely changed our previous understanding.

While it has long been known that the fecal-oral route is by far the usual mode of the infection, the frequency of parenteral transmission is at least lower than previously thought. It has recently been concluded that Hepatitis A "rarely if ever spreads by parenteral mechanisms."⁶ Hepatitis B is infrequently (in U.S.) transmitted orally in casual situations and then it is apparently via saliva and not fecal-oral. Definite non-parenteral sporadic cases do occur. Under institutional circumstances, e.g., mental hospitals, and in the decreased sanitation standards in some lower socioeconomic situations, this mode is greatly increased. This is evidenced by the relatively higher frequency of antibodies to HB_s Ag (and HA Ag) in lower socioeconomic groups in the U.S. as well as certain foreign countries.

"Isolation" criteria, either in the hospital or at home, have now been substantially established. HAV does not spread via salivary or respiratory droplets. It is only necessary to have "stool" isolation and probably needle. "Stool" isolation is not necessary for HBV infections but of course needle is mandatory. It is uncertain whether oral (including respiratory) isolation is necessary but probably is not. Intimate contact is a clear infectious route (both semen and saliva can be HB_s Ag positive), as evidenced by the high rate of subsequent HBV disease in the spouses of acute HB_s Ag positive patients.

The advantage of the early

TABLE 4 FEATURES OF VIRAL HEPATITIS*

	Virus A (HAV)	Virus B (HBV)
Incubation Period	15-45 days	30-160 days
Mode of Transmission		
Oral (Fecal)	Usual	Infrequent (not fecal)
Parenteral	Infrequent	Usual
Other		"Intimate contact"
Symptoms		
Type of onset	Acute	Often insidious
Preicteric	Definite	Sometimes mild
Distinguishing Test	Rising Anti-HA Ag	HB _s Ag positive**
Isolation	"Stool" and needle	Needle and ? "oral"
Mortality Rate*** (Hospitalized patients)	0.5%	Sporadic: under 1% Narcotic related: 2% Post-transfusion: 10%
Sequelae		
Carrier	0	5-10%
Chronic Hepatitis	Rare	10% (parenterally transmitted)
Prophylaxis	Gamma Globulin	Hyper immune gamma globulin**

* Non-A, non-B not listed for lack of current information but is probably like Virus B in many respects except**.

*** Estimating that less than 1/3 of clinical hepatitis patients are hospitalized, the mortality rate of patients in an "average practice" would be reduced by this factor.

establishment of which type of viral hepatitis the patient has is illustrated in both the differing mortality rates and the frequency of sequelae. Even sporadic HBV disease results in more deaths than HAV, and the "carrier" rate is zero for HAV. Whether any form of chronic hepatitis results from HAV remains to be established (presumably they would be antibody negative) but it must be with such low frequency that one may totally reassure patients on the point. The disparity of the data for carrier and chronic hepatitis is due to a different source for each datum and reflects the newness of the science. As previously stated, many carriers also have chronic hepatitis. Of those who have chronic hepatitis originally transmitted parenterally the 10% is divided—7% chronic persistent

and 3% chronic active.

Passive immunization for both HAV and HBV should be done as early as possible for appropriate contacts or exposure per each disease. There is no value after appearance of the acute stage of the illness. Two to five ml of ordinary gamma globulin is used in effective prophylaxis of HAV disease. The usual gamma globulin cannot be considered effective for protection against HBV illness. The partially favorable reports in the literature are probably due to the fortuitously moderately increased antibody to HBV in certain batches of gamma globulin.

Appropriate prophylaxis for Hepatitis B is 0.06 ml/kg of hyper-immune (anti-B) gamma globulin immediately, and after a one-month

interval. Current cost is \$140 per 4 ml.

Active immunization to hepatitis B looks promising. It is based on HB_s Ag positive serum rendered noninfectious¹⁰ and should be available in the near future. Hepatitis A presents a more difficult problem. HA Ag remains positive in the blood for only a short time and/or in insufficiently large concentrations to provide an in vivo source. Tissue culture methods will probably be necessary.¹¹

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See page 898 for Quiz and details as to how to submit your answer sheet for CME credit.

Primary Hyperparathyroidism: A Common Problem

JAMES W. EDMONDSON, M.D.
Indianapolis

P RIMARY hyperparathyroidism (PHP) was once thought to be an obscure disease of little or no concern to the practicing physician. However, the development of multichannel chemical analyzers and their application to screening large numbers of relatively asymptomatic patients has led to the recognition of many new cases of PHP in patients in Indiana and elsewhere.¹ The general diversity of this problem and the recent experience of this medical center with the diagnosis and treatment of PHP have provided the impetus for this report.

Diagnosis

PHP is a disease without striking sexual or racial prevalence but one which is infrequently noted in the adolescent and younger patient. Most patients attain recognition in either of two ways.² Symptoms directly lead to discovery of hypercalcemia and subsequently to a diagnosis of PHP, or hypercalcemia is noted as an incidental laboratory abnormality during evaluation for unrelated medical problems or as a consequence of a routine screening examination. The symptoms exhibited by patients with PHP are multiple and frequently nonspecific, but two types of symptoms have been repeatedly noted. (Table I) Approximately one third of patients with PHP have experienced single or multiple episodes of nephrolithiasis as the consequence of hypercalcemia and hypercalciuria. Although the incidence of PHP in pa-

tients with kidney stone disease is not large, at least one measurement of serum calcium should be made in every stone-forming patient. The second notable class of symptoms is related to skeletal disease and is consequent to the action of parathyroid hormone on the skeleton. Skeletal symptoms may consist of bone pain, repeated fractures, or generalized osteopenia on x-ray. Currently, fewer patients with PHP exhibit skeletal symptoms, and it has been suggested that the declining incidence of skeletal symptoms represents earlier diagnosis.

The most frequently noted mode of presentation today is incidental discovery. The patient may be admitted to the hospital for childbirth, cholecystectomy or other unrelated medical problems, only to serendipitously discover hypercalcemia. Similarly, many patients attain recognition following executive or routine laboratory testing where few, if any, recognizable symptoms are

present. The use of autoanalyzers has contributed most markedly to the recognition of this group.

With few exceptions, hypercalcemia is an invariable feature of primary hyperparathyroidism. Although perturbed calcium homeostasis is the sine qua non for diagnosing PHP, not all patients exhibit hypercalcemia at all times. Consequently, several measurements of serum calcium may be necessary to clearly document hypercalcemia. Recent experience with measurements of ionized calcium indicate that the ionic fraction of serum calcium shows less variation than total calcium and may be a better discriminator for hypercalcemia.³ Consequently, where available, measurements of ionized calcium offer valuable diagnostic information in patients with marginally elevated serum total calcium measurements.

Once hypercalcemia has been established, the etiologies other than PHP need to be excluded. (Table II) Malignancy, the most frequent cause of hypercalcemia, leads to elevated serum calcium (ionized and total) and infrequently may mimic PHP.⁴ Skeletal metastases need not be present to produce hypercalcemia. Careful examination of the patient and his x-rays usually leads to the correct diagnosis. Hyperthyroidism, thiazide diuretic administration and sarcoidosis produce hypercalcemia less frequently and are usually evident following history, physical examination and routinely available clinical laboratory testing. Other etiologies of hypercalcemia are included only to complete the differential diagnosis since they are very infrequently recognized as causes of hypercalcemia.

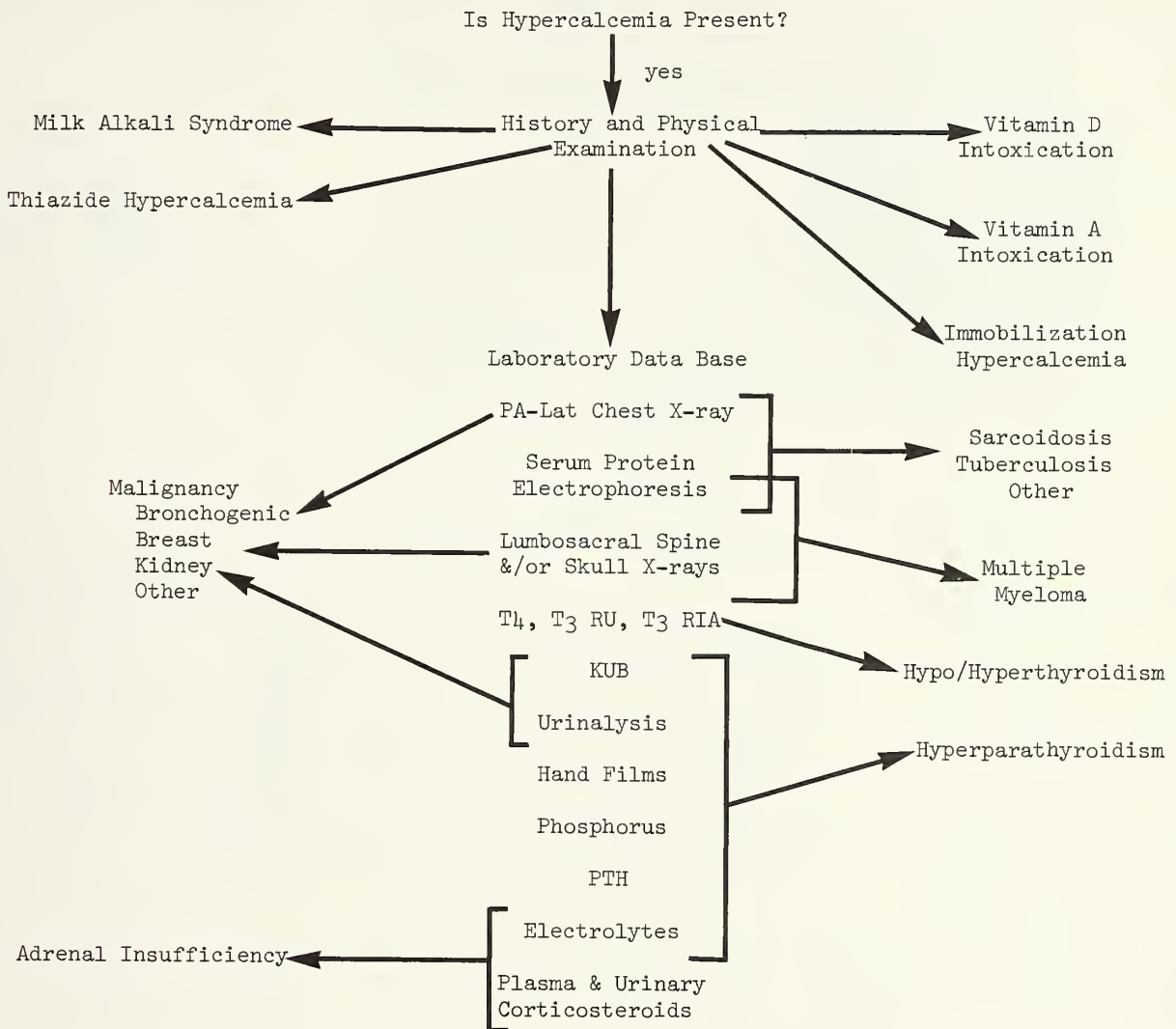
TABLE. I. Presenting Signs and Symptoms in 46 Patients with Primary Hyperparathyroidism

	Number	%
Nephrolithiasis	19	41
Hypertension	16	35
Weakness	9	20
Abdominal pain	8	17
Subperiosteal resorption	8	17
Constipation	7	15
Nervousness	5	11
Peptic ulcer disease	5	11
Arthritis/arthralgia	4	9
Polyuria	4	9
Pancreatitis	2	4
Coma	1	2
Zollinger-Ellison syndrome	1	2
Insulinoma	1	2
Hypocalcemic infant	1	2

From the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

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TABLE II



In addition to serum calcium, other laboratory measurements aid in the diagnosis of PHP. In response to the phosphaturic effect of parathyroid hormone, serum inorganic phosphorus is frequently low. Repeated early morning fasting inorganic phosphorus measurements are diagnostically helpful. Similarly, mild hyperchloremic acidosis with serum chloride measurements greater than 105 mEq/liter is frequently noted and of diagnostic significance. Alkaline phosphatase may be elevated in the sera of patients with skeletal disease. Radiographs of the hands in search of subperiosteal resorption are helpful,

but this finding is less often encountered today.

Ideally, measurements of circulating parathyroid hormone (PTH) should provide the best discrimination for diagnosis. Unfortunately, abundant experience with measurements of PTH in PHP indicates that not all assays of parathyroid hormone detect elevated levels of PTH in all patients. Problems with the diagnostic utility of PTH measurements are largely attributed to the multiple species of the parathyroid hormone molecule in blood.⁵ Improvement in assay technic and characterization of PTH antisera make current PTH measurements

more practical and diagnostically helpful, particularly when coupled to exclusion of other etiologies of hypercalcemia.

Treatment

Having established the diagnosis of PHP, the physician must then be concerned with providing the most appropriate treatment for this disorder. In patients with significant hypercalcemia (greater than 12 mg%) or in whom symptoms are present, e.g., kidney stones, peptic ulcer disease, etc., the treatment of PHP is well defined. Surgery is clearly indicated. The surgical approach to this problem cannot be

considered in detail in this report, but specific goals should be outlined. The increasing frequency of histologically recognized hyperplasia as well as the increasing frequency of recurrent hyperparathyroidism make identification and in vivo marking of the location of remaining parathyroid tissue important surgical goals.⁶ Some centers have adopted the technic of parathyroid autotransplantation into the muscles of the forearm as a means to better localize remaining parathyroid tissue, in the event that additional surgery is required.⁷

The best treatment of the asymptomatic patient with mild hypercalcemia is a current dilemma. Although the natural history of PHP is not well established, not all patients with mild disease have progressive courses.⁸ The physiological significance of mild hypercalcemia is also unknown. A most interesting recent study suggests that many asymptomatic patients with PHP ultimately require surgical treatment because of physiological or emotional decompensation.⁹ Additional experience in the medical management of PHP will be required to establish the proper place for this treatment modality.

Following diagnosis and treatment, additional measures are indicated. As noted, recurring disease is being increasingly recognized. For this reason, posttreatment

measurements of serum calcium are necessary for several years. Familial syndromes of which PHP is a component are also being frequently discovered. Consequently, measurements of serum calcium should also be undertaken in the symptomatic and asymptomatic relatives of patients with PHP. Hence, the detection, treatment and posttreatment observation of patients with PHP and their families are of concern to physicians in all areas of medicine.

We have established a protocol to better define the natural history of asymptomatic primary hyperparathyroidism as a means to improve upon the available treatment for this disease subset. As noted, clinically recognizable skeletal manifestations of PHP occur less frequently today. Sensitive technics for assessing skeletal mass have been developed and are easily applicable to patients with PHP.¹⁰ In the described protocol, serial measurements of skeletal mass by photon absorptiometry will be undertaken as a means to define the rate of change of skeletal mass in patients with asymptomatic PHP. These results, together with serial measurements of ionized and total calcium, PTH and vitamin D metabolites, will be utilized as a means to better separate patients requiring parathyroidectomy from those requiring no treatment.

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New Double-Blind Study ANDROID-25 vs. Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change, + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

The Auxiliary Reports to ISMA



I have asked Mary-Anne Pomputius (Mrs. William F.) of Vincennes, who serves as chairman of Indiana Auxiliary's Project Bank, to discuss this valuable facet of our activities with you this month. We can all take pride in the fact that Indiana has been able to make "deposits" in this "bank" for other auxiliaries to draw upon.

Mary K. Stanley

Mary K. (Mrs. John R.) Stanley
President, ISMA Auxiliary

Project Bank, the four-year-old child of more than 80,000 American Medical Association auxiliaries, provides information on community services implemented nationally. To help improve the quality of life in our community is one real goal of the Auxiliary. A successfully completed program managed by one or many people now can be shared as a valuable resource available nationally.

Need is identified by a proscribed survey, the project is presented with approval of the local County Medical Society, the experience described and recorded on standardized forms and submitted to national headquarters by means of the state and regional coordinators. Catalogued and filed selected projects are presented in brief paragraph for inclusion in the Project Bank Catalogue available free of cost to any county upon request to the State Project Bank Coordinator.

The Project Bank Catalogue, revised yearly, is divided into 13 sections:

Aging	Fund Raising	Mental Health
Blood Donor	Health Careers	Safety Screening
Children and Youth	Health Education	Miscellaneous Package
Family Life	International Health	Program

Additional resources include addresses of related organizations, institutions, individuals and (when available) other county auxiliary programs. The Bank depends upon grass roots "deposits" for national "withdrawals."

Indiana can be proud of several "deposits" including the life-saving skills of Cardiovascular Pulmonary Resuscitation (CPR) of Evansville (Vanderburgh-Southwestern) which received extensive television and newspaper coverage. This innovative, ongoing program of community instruction is now available step-by-step to every county in the nation. In Terre Haute (Vigo County) it was discovered that many organizations dealing with youth had no First Aid Kits for routine simple emergency care. The Auxiliary assembled kits and distributed them to all youth-related groups, a simple yet vital need of one community. Large or small, the projects are relevant to improving life. Let me mention several projects across the nation:

—Jefferson County (Ky.) "Cooking Classes for Senior Citizens." On the same subject but a different approach, Milwaukee "Nutrition Program—The Chef's Choice," teaching dietary and cooking skills by actual food preparation for and by retired men.

—A program in Kankakee, Ill. "What Every Doctor's Spouse Should Know" covering legal responsibilities of a surviving spouse upon the death of a physician-spouse.

—Two lectures on "Death and Dying" in High Point (Guilford County), N.C., drew 1,200 and 1,300 people each!

—Various programs in communities to screen for scoliosis, hypertension, audio and visual problems.

Essentially, the Project Bank is service communication at its best within Indiana and throughout the United States. Proven and tested program information readily available from our location can be tailored to the needs and volunteers available in another location. County "dividends" from the national "endowment" continue to help improve the quality of life in Indiana.

MARY-ANNE K. POMPUTIUS
Vincennes



Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

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BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg/kg/day in rabbits and 10 mg/kg/day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.


Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

*** Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

*** Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions:
Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions;

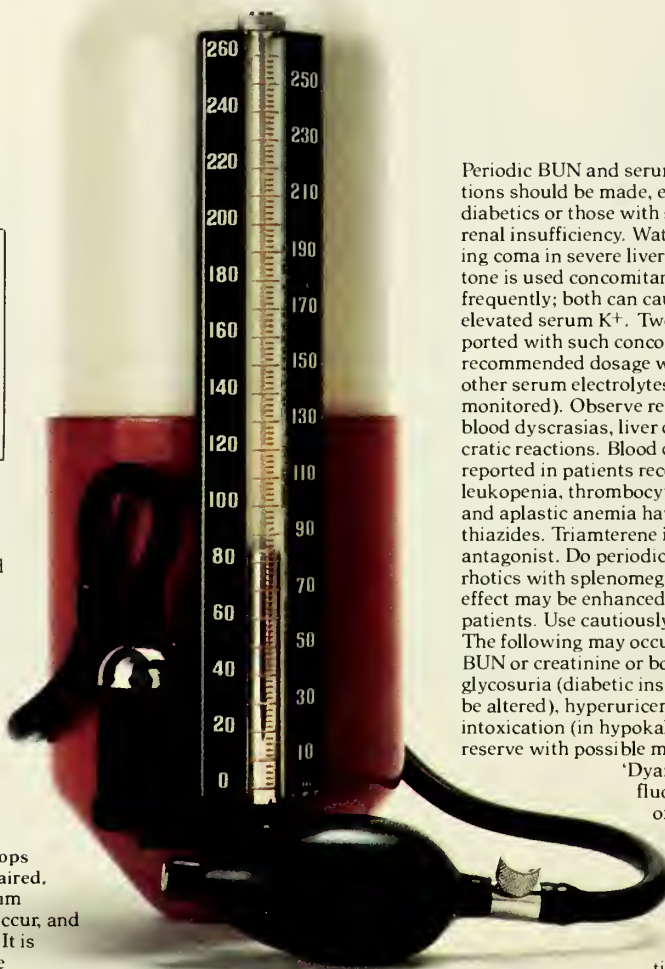
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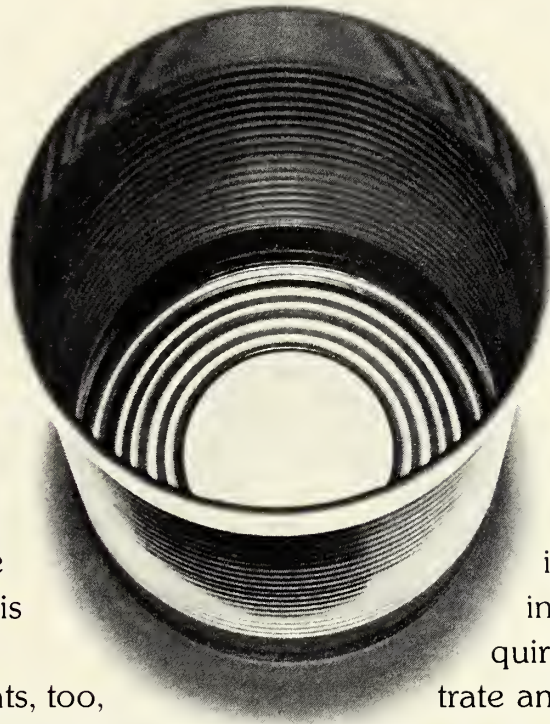
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Drugs in the Treatment of Hypertension: Pharmacology and Interactions

ARUNABHA GANGULY, M.D.
Indianapolis

It has been well-documented that treatment of severe hypertension reduces both mortality and morbidity. The recent VA cooperative study suggests that treatment of even milder forms of hypertension alters the long-term prognosis appreciably. The inevitable conclusion from these observations is that all patients with hypertension should be treated adequately once the initial evaluation has been completed.

There are a growing number of effective antihypertensive agents at our disposal which can be separated into the following categories:

- I) Diuretics,
- II) Drugs acting on the adrenergic nervous system,
- III) Vasodilators and
- IV) New Drugs.

I. Diuretics are the keystone of therapy for hypertension. A number of thiazide and non-thiazide diuretics (e.g., chlorthalidone, quinethazone, metolazone, spironolactone, triamterene) are available. These drugs usually have a maximally effective dose. For hydrochlorthiazide it is 50 to 100 mg a day, for chlorthalidone 100 to 200 mg, for furosemide 80 to 100 mg a day. The initial effect of the diuretics is entirely related to sodium and water diuresis. But, at least for the thiazides, it has been suggested that the long-term effect may be mediated by the relaxation of precapillary resistance vessels. Furosemide offers no special advantage

over thiazides except in patients with impaired renal functions. In the latter situation it is the preferred drug. Furosemide may induce more severe fluid and electrolyte abnormalities and must be given several times a day because of its short duration of action. The potassium-sparing agents, spironolactone and triamterene are weak diuretics at best but may be used to combat the hypokalemic effects of other diuretics. Spironolactone is very effective in relatively high doses in certain forms of hypertension, e.g., primary aldosteronism and low renin hypertension.

Side effects of diuretics are hypokalemia and hyperuricemia. With thiazides, hyperglycemia or aggravation of existing diabetes mellitus is an additional problem. Such complications may be less common with furosemide or chlorthalidone. Drug rash can also be seen with thiazides. Triamterene and spironolactone may cause hyperkalemia, especially if potassium supplements are also given or if renal failure is present. Spironolactone often causes impotence and gynecomastia in men and menstrual irregularities in women.

Diuretic-induced hypokalemia may enhance the development of digitalis toxicity. Lithium toxicity is said to increase with diuretic therapy.

II. Drugs acting on the adrenergic nervous system.

a. **Methyldopa (Aldomet)** may be effective in some cases of hypertension but in severe forms it usually is not adequate. The effective oral dose is between 0.5 and 3 gm

a day in divided doses. Larger doses are not expected to increase its antihypertensive effect.

Its mode of action is probably dual. Methyldopa acts as a false neurotransmitter, but is less potent than norepinephrine and decreases sympathetic neuronal activity. It probably also acts centrally reducing sympathetic discharge. The latter may be its principal mode of action.

The major side effect of methyldopa is sedation, which may be transient, lasting for a few days to a few weeks. Postural hypotension occurs less frequently than with other sympatho-inhibitory drugs but sexual dysfunction in males is common. Other undesirable effects include drug fever, hepatic dysfunction, positive Coomb's test and, rarely, hemolytic anemia and lactation in females.

The use of sympathomimetic drugs may reverse the antihypertensive effect of methyldopa. Interaction with antidepressant drugs does not occur, but methyldopa may increase the toxicity of haloperidol.

b. **Guanethidine (Ismelin)** acts by preventing release of norepinephrine at the post-ganglionic nerve terminals. It has been used mainly in patients with severe hypertension, requiring large doses with frequently unpleasant effects. It has several major side effects. Postural hypotension is frequent and can be disabling. Sexual dysfunction in males and diarrhea are common. Exercise-induced hypotension can occur. Hypotension can

From the Specialized Center of Research (SCOR) in Hypertension, Indiana University School of Medicine, Indianapolis 46202.

be aggravated by alcohol ingestion. The usual dose is between 25 and 150 mg a day. The drug has a cumulative effect and, therefore, a prolonged action is observed after discontinuation. For this reason, increases in dosage must be gradual, and both supine and erect blood pressure must be measured. Unlike methyl dopa and reserpine, guanethidine does not cross the blood-brain barrier.

Resistance to the antihypertensive effect of guanethidine may occur either due to sodium retention or to enhanced sensitivity to endogenous norepinephrine. These problems can be circumvented by adding a diuretic or using phenoxybenzamine (Dibenzylamine).

Tricyclic antidepressants (e.g., imipramine, nortriptyline, etc.) block the uptake of guanethidine at the nerve endings, thereby rendering it ineffective—another cause of drug resistance. Some of the phenothiazine drugs, as well as amphetamines, also interfere with its action.

c. **Rauwolfia alkaloids** (e.g., reserpine): Reserpine, once quite popular, has been used less commonly in recent years. It can be an effective drug for mild to moderate hypertension if given in adequate doses (0.25-0.5 mg/day). Its mode of action includes interference with neurotransmission at peripheral nerve endings and a centrally mediated action at the vasomotor center, both related to the depletion of catecholamine stores.

Unfortunately, an adequate therapeutic response often cannot be achieved without causing unpleasant symptoms. Major side effects include nasal stuffiness, Parkinsonian rigidity and increased gastric acid secretion resulting in peptic ulceration. Depressive psychosis has been the major reason for the decline in its use. Depression appears to be dose-related and, less common below 0.5 gm a day, may occur rather insidiously, may last quite some time after discontinuance and is not amenable to treatment with tricyclic antidepressants. Monoaminoxidase inhibitors, if given together with reserpine, may re-

sult in pressor responses.

d. **Propranolol (Inderal)** has become one of the most popular and effective drugs in the treatment of hypertension. It is a beta-adrenergic blocking agent. Its hypotensive action is due to reduction of cardiac output. It also inhibits release of renin (which is a pressor agent) from the kidneys and therefore may block the vasoconstrictor action of renin. A third possible locus of action may be in the central nervous system.

The therapeutic effect is usually seen at a dose of 160-320 mg a day or less, but sometimes, especially in severe hypertension, an additional hypotensive effect is observed up to a dose of 1 or 2 grams a day. At such doses side effects may be important and cost can be prohibitive. The drug is contraindicated in patients with (1) bronchial asthma, (2) chronic obstructive lung disease, (3) frank congestive heart failure, (4) sinus bradycardia and greater than first degree heart block and (5) allergic rhinitis due to pollen. In the presence of mild heart failure, if the latter is believed to be due to hypertension per se, propranolol may be used cautiously in conjunction with diuretics and digitalis.

The drug is fairly well tolerated. Bradycardia and fatigue are relatively innocuous effects. However, the dosage must be adjusted if heart rate is below 50-60 per minute. Heart failure may be precipitated in unsuspected patients. Bronchospasm may occur in patients with history of asthma. Propranolol may mask symptoms of hypoglycemia in insulin-requiring diabetics. Sudden withdrawal of the drug may cause unstable angina, cardiac arrhythmia or even myocardial infarction. Most patients can be effectively treated with a twice-daily dose.

III. Vasodilators:

Hydralazine (Apresoline) is the prototype of this group and is the only vasodilator currently available for long-term oral therapy. The usual effective dosage is between 100 and 200 mg a day in divided doses.

Current data suggest that it may effectively be given twice a day in most patients rather than four times a day. The drug acts directly on peripheral arterioles, causing dilatation and thereby lowering peripheral resistance. As with most vasodilators, sodium retention and reflex increase in sympathetic activity results in increased cardiac output. It should, therefore, usually be given with a diuretic and, if necessary, a sympathetic blocking agent such as propranolol, methyl dopa or reserpine. If given alone, it may cause palpitations and throbbing headache. Anorexia, nausea, diarrhea and nasal congestion may occur. A systemic lupus-like syndrome may occur rarely but is unusual if the dosage is less than 400 mg a day. Since the drug is capable of increasing the myocardial metabolic rate, angina may be precipitated or aggravated in the presence of coronary artery disease. It should be avoided when dissecting aneurysm is present.

Other vasodilators. Diazoxide and sodium nitroprusside are powerful vasodilators which can be given intravenously only and are used only for rapid lowering of blood pressure during a hypertensive crisis.

IV. New Drugs

Some new drugs which have been under trial or are already in use, such as clonidine, prazosin, minoxidil and guancydine will be discussed in a subsequent communication.

Principle and plan of therapy

Diuretics play a key role in the treatment of hypertension. One of the diuretics is the first drug of choice although some physicians may initiate therapy with propranolol and add a diuretic subsequently. In mild cases diuretics alone may be effective. Some degree of dietary salt restriction is indicated, since the antihypertensive benefit of diuretics can be reversed by increased sodium intake.

In moderate to severe hypertension combination therapy is required. The second drug should be one of the adrenergic block-

ing drugs—propranolol, reserpine, methyl dopa or guanethidine. Propranolol is now the most commonly used agent unless there is some contraindication to its use. Once an adequate dosage has been reached (160-320 mg/d), a third drug may be required, which will usually be a vasodilator. Currently, hydralazine appears to be the drug of choice. It can be given up to 300 mg a day if tolerated. If necessary, the dosage of propranolol could be further increased. We have occasionally given up to 960 mg a day

in severe hypertension with gratifying results. One must, however, watch out for severe bradycardia or heart failure.

In essence, the therapy of hypertension is directed to ensure adequate volume depletion and sodium loss, supplemented by blockade of neurogenic vasoconstriction and induction of active vasodilatation of peripheral arterioles. Cardiac output is also usually decreased by these agents.

It is essential for the physician and the patient to realize that in

most instances antihypertensive therapy is required for the rest of the patient's life. For the patient to be able to take the drug continuously, side effects have to be tolerable. Therefore, an appropriate strategy which is best suited to deal with the stated goals must be adopted so that compliance and control of blood pressure can be maintained. The patient must be educated that side effects may occur and asked to report them so that appropriate measures or changes in medication can be made. ◀

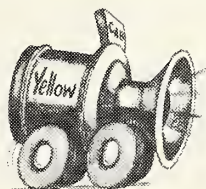


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Guest Editorial

OSHA Pushes High-Cost Noise Control

If you found yourself too far out on a limb, you'd probably crawl back to the safety of the trunk. In the same position, however, the Occupational Safety and Health Administration would undoubtedly recommend building a new tree under the outer end of the limb.

That's the impression you're left with after reviewing OSHA's proposed noise control regulations.

At issue is how best to protect workers' hearing from noisy machinery.

Employers want to use a hearing-conservation program built around ear plugs or special ear muffs (like hi-fi headphones), at a cost of \$42

per worker per year.

OSHA want to redesign or cover up noisy machinery, at a cost of \$8 billion, or \$267,000 per worker benefited. And that's just OSHA's estimate of the cost, which was reached by "revising" the work of its own consultants until the figure looked low enough. Industry experts believe true costs would be many times higher.

OSHA's first study, done in 1974, put the cost of machinery redesign at \$31.6 billion, to achieve noise levels no higher than 85 dBA (about as noisy as a busy urban street corner).

The same consulting firm that conducted the first study for OSHA did another, in 1975. The economic impact figures were still embarrassing, so the study was resubmitted to the consultant for "revision." After "revision," the cost figure was \$18.5 billion for an

85 dBA limit, or \$10.5 billion for an easier-to-meet, 90 dBA limit. And, interestingly enough, much less was said about the effect on inflation and unemployment.

OSHA then reasoned that since it had proclaimed a 90 dBA limit in 1971, it could be assumed industry had already absorbed the \$10.5 billion cost of that. Therefore, moving to an 85 dBA limit would cost only an extra \$8 billion (\$18.5 billion minus \$10.5 billion). Thus, the \$10.5 billion this excessive program is already costing industry was conveniently dropped out of the total cost figure.

In other words, it doesn't matter to OSHA what costs are in the real world, as long as they can be made to look low enough on paper.

Through cross-examination during OSHA's hearing on the proposed regulations, we learned that OSHA's consultant used old data

on some of the industrial sites it claimed to have visited in the course of its studies, and made off-the-cuff estimates of the noise level in those plants it did visit. That is, noise levels were estimated without the benefit of scientific measuring instruments—a notoriously unreliable procedure, because the human ear is easy to fool.

In another instance, this consultant selected an arbitrary figure as the "cost" of noise-proofing machinery that cannot—at the present state of technology—be made to operate quietly. In fact, the consultant's witness admitted his cost figures were often based on "intuition."

Under the circumstances, it's easy to see why OSHA has refused to provide documentation for all its claims, even after the Chamber filed a formal Freedom of Information Act request for it.

Noise control is important. Continued exposure to high levels of noise can cause permanent loss of hearing in susceptible individuals. But how on earth can an expenditure of \$267,000 per worker be justified, when adequate protection is available for \$42?

OSHA is up a tree trying to fabricate a convincing answer to that one.—**Richard L. Leshner**, president, Chamber of Commerce of the United States.

Editorial Notes . . .

Dr. Robert B. Hunter, chairman of the AMA Board of Trustees, was the AMA spokesman when the

AMA was asked to make comment on "Background Report on Surgery in the State Medicaid Programs," a document which was originated by the staff of the Subcommittee on Oversight and Investigations of the House of Representatives. Dr. Hunter has said that the report reveals that the Medicaid program is nothing less than an administrative horror. Also: The report should be required reading for anyone who gives serious attention to proposals that would extend government management further into medical care.

Varian Associates and Orthopedic Equipment Company of Bourbon, Ind., announce a unique type of x-ray equipment for diagnostic purposes in the operating room. The OEC/Varian machine automatically determines patient "density" and, with a minimum of x-ray exposure, stores the images and displays them on a TV-type monitor. It is used in surgical procedures for pacemaker implants, hip pinning, long bone nailing, gallbladder operations, needle biopsies, neurosurgery and locating foreign bodies.

The Epilepsy Foundation of America is interested in the FDA approval of sodium valproate, a drug with demonstrable advantages in epilepsy. It has been used in France since 1967 and is now available almost any place except the United States. The FDA ignores the foreign clinical experience. The Epilepsy Foundation thinks FDA should recognize the drug's 10-year record and approve it for Americans.

CT scanners can sharply reduce the costs of diagnosing abdominal and pelvic conditions, according to a study made in Britain. Data from nine community hospitals in England show that as much as \$3,000 can be saved through shorter hospital stays, elimination of other diagnostic tests and exploratory surgery. HEALTH NEWS REPORT comments that the report comes at a time when American hospitals are being accused of extravagance in acquisition of scanners. In fact, the scanners may be worth every cent they cost and more.

Herpes virus encephalitis has been treated successfully for the first time with adenine arabinoside (ara-A). The drug is in its investigational stage. The National Institute of Allergy and Infectious Diseases and the Parke Davis Research Laboratories plan to investigate the anti-viral capabilities of ara-A very thoroughly.

Interesting results from Harris Poll on public opinions about hospital cost control. The Talmadge plan got 38.4% of the votes—The Carter plan got 38.2%. Nearly two thirds thought price controls on hospitals without controls on labor and supplies would be unfair. A sizeable majority thought government involvement will add to hospital costs without improving quality. There is a deep public aversion to federal promises of controlling hospital costs. ◀

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TAX TIPS

LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

Prior to the Tax Reform Act of 1976, §2035 stated, in general, that if an individual made a gift during the individual's lifetime and died within three years after making the gift, then there was a rebuttable presumption that the individual had made the gift in contemplation of death. As a consequence, if the decedent's personal representative did not rebut the presumption (by proving that the decedent made the gift with lifetime motives instead of death motives), then the value of the gift, at the decedent's death, was includable in the decedent's gross estate for federal estate tax purposes. This "old" rule continues to apply for gifts which were made by an individual prior to 1977. Thus, for a decedent who dies after 1976, the Internal Revenue Service can continue to maintain that certain gifts which were made by the decedent within three years of the decedent's death and prior to 1977 are includable in the decedent's gross estate, using the value of the gift at the decedent's death or at the alternative valuation date. And such a decedent's personal representative will continue to argue such cases on the basis of such old rules.

However, as to gifts which an individual makes after 1976 (and, obviously, for an individual who dies after 1976), the Tax Reform Act of 1976 provides, under new §2035(a), that all such three-year gifts are *automatically* includable in the decedent's gross estate at the value of the gift at the decedent's death (or at the alternative valuation date) regardless of the decedent's motive at the time of making the gift. Further, §2035(c) now provides that all gift taxes which are paid by the decedent on such lifetime transfers are includable in the decedent's gross estate. The theory of including the gift taxes in the decedent's gross estate is to

align the facts, as nearly as possible, as though the gifts had never been made and the gift taxes never been paid. There is, then, what is referred to as a complete "gross-up" of such gifts and such gift taxes.

The only two statutory exceptions to these new rules are contained in §2035(b). First, the new rule does not apply to any bona fide sale for an adequate consideration in money or money's worth. And, second, the new rule does not apply to any gift which is excludable in computing the decedent's taxable gifts due to the \$3,000 annual exclusion for gifts of present interests, which exclusion is provided for in §2503(b). In applying this latter rule, the decedent's estate must include the entire value of the gift without regard to any exclusion which the decedent's spouse utilizes in computing such spouse's taxable gifts. That is, if a decedent makes a gift to someone other than the decedent's spouse, and the decedent and the decedent's spouse elect to split the gift, for gift tax purposes, and as a result, the spouse utilizes the spouse's annual \$3,000 exclusion, and the decedent dies within three years after making the gift, then the otherwise appropriate value of the gift will be includable in the decedent's gross estate without reduction for the spouse's exclusion so utilized.

There are two major problems concerning the application of the new rule. The first problem concerns the amount of the decedent's lifetime \$3,000 annual exclusion which will be allowed to reduce the value of any gift which is required to be included in a decedent's gross estate under the new general rule of §2035(a). Clearly, if a decedent makes a gift of a present interest to a third person, when the value of the gift is, for example, \$10,000, then, regardless whether the gift is split with the decedent's spouse for gift tax purposes, the amount of the includable gift, for estate tax purposes, at the decedent's death (or at the alternative valuation date) will be reduced by *one* (the decedent's) \$3,000 exclusion. Therefore, if the value of the total gift is, for example, \$20,000 at the decedent's death, and the decedent's personal representative uses the date of death values, for estate tax purposes, then the value of this gift which is includable in the decedent's gross estate is \$17,000 (\$20,000 less \$3,000). In addition, the gross estate must include any gift taxes which the decedent (or the decedent's personal representative) pays in respect to the gift.

On the other hand, if the value of the gift was, for example, \$2,000 and the decedent did not elect to split the gift, so that that decedent used only \$2,000 of the decedent's annual exclusion in respect to the gift, then the question

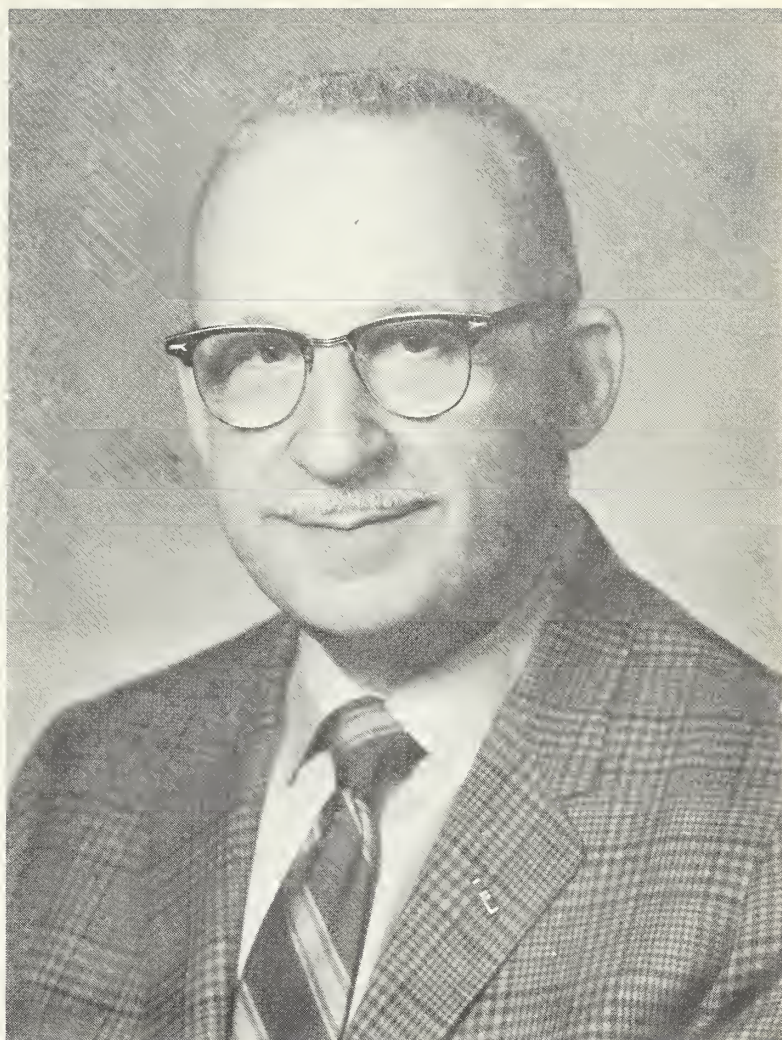
arises as to whether the value of the gift, for estate tax purposes, is to be reduced by the \$2,000 exclusion so used or by the full \$3,000 exclusion which the decedent could have used if the value of the gift had been \$3,000 or more at the date of the gift. While the answer to this question cannot be determined by reading §2035 alone, the Internal Revenue Service is taking the view that only the amount of the exclusion which the decedent actually used may reduce the value which is otherwise includable for estate tax purposes. Thus, under this view, in the case of the \$2,000 gift, if the value of the gift which was otherwise includable for estate tax purposes was \$10,000, then the gross estate must include \$8,000 (\$10,000 less \$2,000).

At present this problem is made even more complex by a proposal which is contained in the Technical, Clerical and Conforming Amendments Bill (H.R. 6715) which was introduced in the House of Representatives on April 28, 1977. The purpose of this Bill is to correct many of the errors which are contained in the Tax Reform Act of 1976. And one of the provisions in this proposed law states that if a decedent did not have to file a gift tax return for the entire year, in respect to gifts to a particular donee, then *none* of the value of the gift, at the donor's death, need be included in the decedent's gross estate, even though the gift is made within the three-year period of time.

Ostensibly, this proposal changes the present §2035(b) in two respects. First, if the gifts are entirely excluded, for gift tax purposes, by the donor's annual exclusion, then *none* of the gifts are includable in the decedent's gross estate, for estate tax purposes, no matter what the value of the gifts are at the date of the decedent's death. Under the current wording of §2035 (and unlike pre-1977 law), a donor could make, on the donor's deathbed, gifts of \$3,000 or less to one or more donees, and none of the values of the gifts would be includable in the donor's gross estate, for estate tax purposes, *so long as* the values of the gifts were \$3,000 or less (per gift) at the time of the donor's death. Second, the proposal appears to include in the decedent's gross estate the entire value of any gifts which are required to be reported on a gift tax return. Thus, in the latter case, if gifts are required to be reported on a gift tax return, then the full value of the gifts at the decedent's death (or at the alternative valuation date) are includable in the decedent's gross estate without reduction for any annual exclusion which the decedent might have used for gift tax purposes.

I shall continue my discussion of §2035 in my next article. ◀

ELI GOODMAN, M.D.
President
Indiana State Medical Association
1977-78



Dr. Eli Goodman was elevated to the presidency of the Indiana State Medical Association during ceremonies of the 128th annual meeting. Dr. Goodman, having spent an extremely busy year as president-elect, was installed on October 25.

Dr. Goodman is a native of Boston. He was educated in grade schools and finished his high school work in the Latin School of Boston. His undergraduate and premedical college education was obtained at the University of Louisville, following which he was a student at Tufts Medical College and was awarded the M.D. degree in 1938.

He served first as an intern and then as resident at Woodlawn Hospital in Chicago and then served for six years in the U.S. Army Medical Corps. Three years of his service were spent in the Pacific Theatre. He and Margaret Spencer were married in Port Moresby, New Guinea, during the war.

Dr. Goodman entered medical practice in Charlestown in 1946 and has specialized in family medicine. He has always been active in the many medical societies of which he was a member. As a dedicated physician he has been president and secretary of both the Clark County Medical Society and the Third District Medical Society.

He represented the Third District as trustee for six years and was chairman of the Board of Trustees in 1975-76. He has served on numerous State Association committees, including the one on Constitution and Bylaws, on which he served two terms from 1968 to 1974. Prior to this he was delegate for three years.

Dr. Goodman is well known for his devotion to civic duty, having worked with Red Cross, the Community Chest, his own Area Comprehensive Health Planning Council and the Charlestown Civil Defense Unit.



BOOK REVIEWS

REVIEW OF MEDICAL PHYSIOLOGY

William F. Ganong, M.D., Lange Medical Publications, Los Altos, Calif., 1977; 8th edition, \$12.50, 565 pages.

Review of Medical Physiology, 8th edition, written by Dr. Ganong, professor of Physiology, University of California School of Medicine, San Francisco, is a Lange Medical Publication providing a condensed summary of human physiology, including its relevance to disease states. It is, therefore, an ideal introduction to perverted physiology, or pathology.

Like all Lange Medical Publications, this book is frequently revised and republished in an attractive form, which includes a sturdy plastic cover, easily readable type, a lucid writing style, and numerous black-and-white illustrations, most of which are line drawings. The cost of the publication is \$12.50—remarkably economical for a book comprising 565 information-packed pages. The book is recommended without reservation to medical students, graduate nursing students, other members of the allied health professions taking graduate

courses, and physicians—not only for reference, but for a review of human physiology and its relationship to pathology.

W. D. SNIVELY, JR., M.D.
Evansville

GIVE ME LIFE

William J. Pierce, M.D., Dor Nic Publishers, Bruceville, Indiana; \$4.98.

This treatise on coronary heart disease is an entirely new approach in the evaluation of the nation's number one killer—Coronary Heart Disease associated with early or late arteriosclerosis and hypertension. This is not a situation of old age but has had increasing involvement in young people and in this light efforts are being made to be alerted as to the conditions producing the disability and hopeful of eliminating the process entirely.

Statistics note that 38% of all deaths in the United States are due to heart disease and 17% of deaths are due to strokes. The outlook is somewhat more encouraging since public education about the cause, the frequency and the need of a better understanding of the existing conditions and the alerting of both the layman and physicians to the problem. The decline in coronary artery disease began to show up in 1966 and, since 1973, deaths from heart attacks have dropped 7% and an equal drop is noted in the fatal stroke cases. What is the overall picture as we see it today?

Dr. William Pierce has presented a unique but simple evaluation of the problem in this publication, *Give Me Life*, in his quote "I feel that vaccination against disease is more important than a cure following debilitation." Great strides in this area have been forthcoming in the past years especially in the field of Pediatrics. Early vaccination against polio, measles, whooping cough, mumps, etc., has brought about a definite reduction in the number of cases and the too often serious complications noted in the unvaccinated individuals. Why not do this in the early stages of vascular disease? It is with this thought in mind that the author has shown a need of establishing the early tendencies in patients toward certain cardiovascular diseases, hypertension, diabetes, glandular dysfunctions and many other early detectable pathological conditions which could develop into a well-defined symptomatic disease it as hoped could be controlled though not cured and might eventually require heroic measures such as heart transplants, coronary artery bypasses, kidney transplants, valve replacement and chemotherapy. These procedures have certainly shown a remarkable advancement in preventing a seriously incapacitated patient from becoming a statistic in the Board of Health records.

It is generally accepted, however, that the various emergency procedures heralded as a solution to some heart problems are really only temporary in the restoration of good health. This opinion is expressed by Dr. Pierce and, as a solution to this worldwide problem, he suggests a good educational program by the medical profession. The theme is "stop the disease before it starts." The theory, as suggested by Dr. Pierce, can be initiated by routine physical examinations with a good history, performing simple procedures, determining the inherited tendencies, environmental exposure, industrial components, dietary management and any other information available to consider the future of the patient.

This book is an outline of the new concept of preventative medicine rather than the attempt to cure a condition which has reached the disabling level and is certainly a book which should be reviewed by all physicians for their own benefit and this information should be transmitted to the patients as seen on a daily basis.

IRVIN W. WILKENS, M.D.
Indianapolis

Continued on page 892

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2 **Planning Guide for Physicians' Medical Facilities** (OP-439) \$2.00

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1977 publication which features: economic factors, advantages and disadvantages of incorporation; effect of ERISA on professional corporations; choosing a retirement plan; and managing a professional corporation.

8 **New Doctor's Kit** (OP-458) \$10.00

Contains: **The Business Side of Medical Practice**; **Planning Guide for Physicians' Medical Facilities**; **AMA Publications Lists**; **Group Practice Guidelines**; **Current Procedural Terminology** order form; Uniform Health Insurance Claim Form; **Medicolegal Forms**; **Talking with Patients**; **Preparing a Patient Information Booklet**; AMA membership information; Placement Service; and bibliography on billing systems, recording keeping systems, etc.

9 **Group Practice Kit** (OP-457) \$7.50

Contains: **Group Practice Guidelines**; **Professional Corporations in Perspective**; medicolegal reprints on such subjects as: professional liability, confidentiality, informed consent, etc.; samples of model legal agreements for a physician and employed associate, office sharing, medical partnerships, and forming a corporation.



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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

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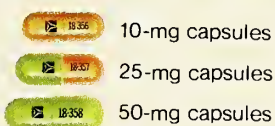


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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psycho-

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tropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relation-

ship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults.* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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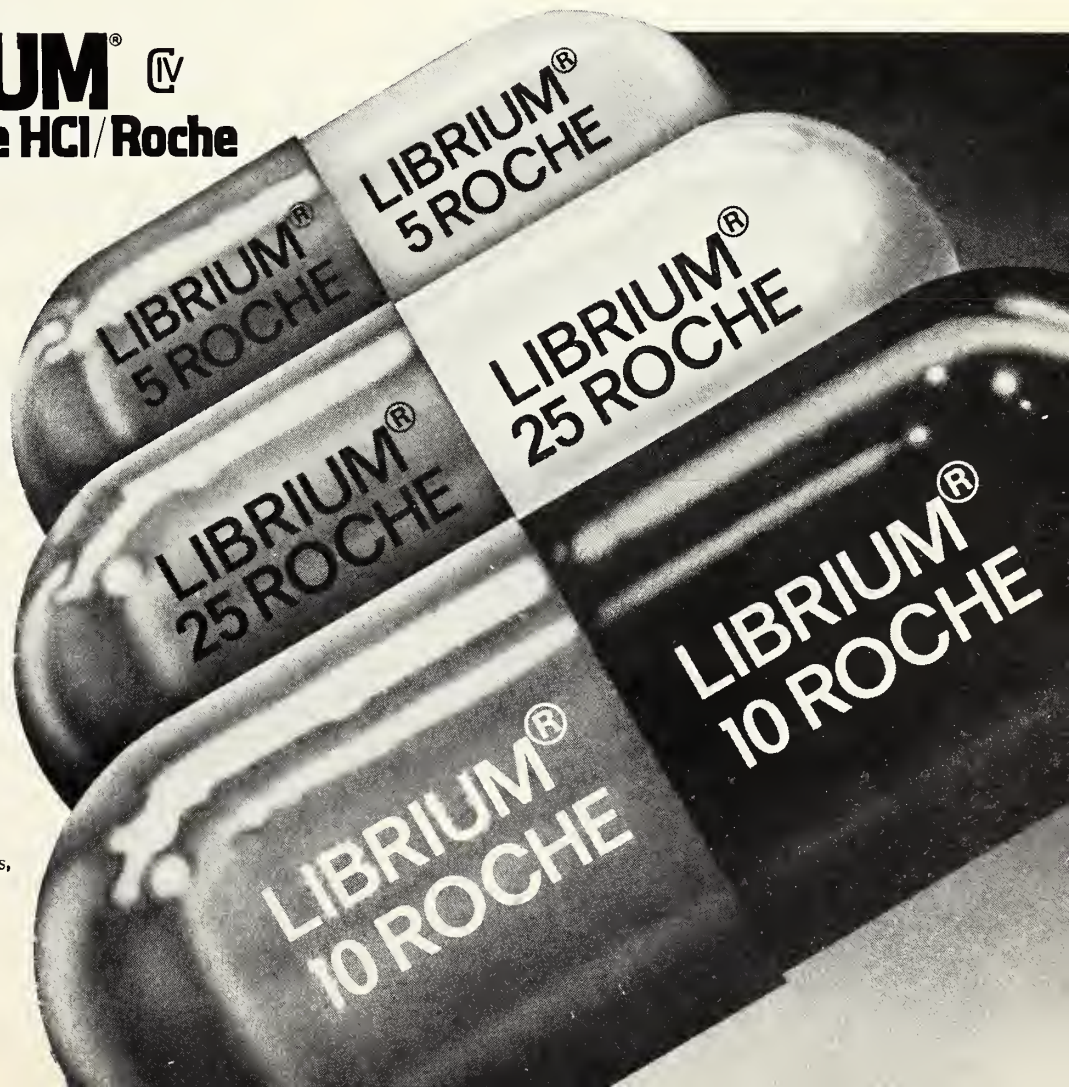
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Please see preceding page for a summary of product information.

ABDOMINAL ULTRASOUND

H. H. Holm, J. K. Kristensen, J. F. Petersen, S. N. Rasmussen, S. Hancke, University Park Press, Baltimore, 1977; 181 pages; \$47.50.

Examinations which cause no debility in and of themselves are always welcome diagnostic tools. Ultrasound, which has been developed since the invention of submarine sonar at the time of World War II, is such a modality and, although frequently supplementary to other means of diagnosis, is becoming very sophisticated and efficient. The Introduction to this volume from Denmark states that the material presented is based on 15,000 abdominal examinations with ultrasound.

There is a fine history of abdominal scanning followed by an erudite section on the physics of ultrasound (it is based on the "piezo-electric effect," such as found in nature with quartz). Then 19 chapters cover the general practical methods and each abdominal organ or system, including female reproductive, renal, great vessels and so on. Chapter 16 details the use of ultrasonically guided percutaneous puncture and biopsy. This last appeals especially to me as very practical and effective. Finally, an Index concludes the book.

An interesting fact is that the first scans were performed with the patient submerged in a water bath (a B-29 gun turret)! The simplest registration of echoes is the so-called "A-mode," which is recorded on a graph. The "B scanning" is two-dimensional and can be photographed from the oscilloscope as a cross section. The gray scale technic photographs all the scans which are registered as dots and is useful in differentia-

tion between soft tissues since this gives information about the internal appearance of organs.

The book was written apparently in English by these Danish physicians and then the syntax was improved by an American radiologist. There remain a few awkward rhetorical phrases. This is, of course, a small criticism and the volume serves the purpose of initiating the reader into this interesting newer, nonpenetrating, nontraumatic diagnostic method.

RODNEY A. MANNION, M.D.
LaPorte

GENERAL OPHTHALMOLOGY

Daniel Vaughan, M.D., Taylor Asbury, M.D., Lang Medical Publications, Los Altos, CA, 1977.

The 8th edition of the "Yellow Book" maintains the format and integrity that has won it an important place in the educational material available to the medical student and the general physician. This new edition has increased only very slightly in bulk but significantly in content and quality of presentation. The clarity of exposition is maintained, thus assuring its continued value to those who need a ready and usable text. The materials are authoritatively presented and the illustrations are clear and offer a valuable adjunct to the incisive narrative. The pathology and therapy of ophthalmic disorders are presented in a manner which assures an excellent understanding of the subject without requiring advanced training in ophthalmology.

In my opinion, this edition can be of value to the ophthalmologist, since it will provide new information with an updating of both procedures and knowledge with the format lending itself to ready reference. Excellent information is presented on the systemic manifestations of eye disease, the use of computerized tomography in diagnosis and the public health aspects of blindness. The new material is especially commended to your attention for its impact on the practice of the generalist and for offering the student an opportunity to have a more comprehensive grasp of eye problems.

An excellent and usable index is provided and the soft-bound volume is unequivocally recommended. Its broad coverage and lucid presentation make it an excellent addition to your working library at \$12.00.

A. C. OFFUTT, M.D.
Indianapolis

THE NERVOUS SYSTEM

William F. Ganong, M.D., Lange Medical Publications, Los Altos, Calif., 1977. 212 pages, \$8.00.

This volume, written by Dr. Ganong, professor of physiology at the University of California, San Francisco, is published in response to requests to publish as a separate book the section of his *Review of Medical Physiology* that deal with the nervous system. The result is an authoritative short text that deals with the nervous system and its functions so that one need not purchase a complete textbook on physiology. The result is a text of some 212 pages, with a price tag of \$8. The binding, like that of other Lange Medical Publications, is sturdy, attractive plastic. Illustrations are in black and white and consist of charts, graphs, line drawings, and photomicrographs.

This text should especially appeal to those giving short courses on the nervous system to members of the allied health professions, such as nurses in graduate studies and physical therapists. The book should also provide a useful review for physicians especially interested in the nervous system. Because of its limited scope, it does not appear suited to the needs of medical students.

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CURRENT OBSTETRICS AND GYNECOLOGIC
DIAGNOSIS AND TREATMENT

Ralph C. Benson, M.D., editor, Lange Medical Publications, Los Altos, Calif., 1976; 912 pages, illustrated, \$16.00.

This book was written by 42 authors and has 43 chapters in addition to appendix and conversion charts. It covers all aspects of obstetrics and gynecology with emphasis on diagnosis and treatment. The significant embryology, anatomy and preventive aspects are also covered. The references mentioned in the text are as current as possible and include some of those published in 1976.

The book also has chapters on diseases of the breast and antimicrobial chemotherapy. The printing and illustrations are generally good. The cost is quite reasonable. I recommend this book highly, particularly for busy residents and practicing physicians. The publisher has promised to publish a new edition within two years.

WEI-PING LOH, M.D.
Gary

REVIEW OF PHYSIOLOGICAL CHEMISTRY

Harold A. Harper, Ph.D., Victor W. Rodwell, Ph.D., Peter A. Mayes, Ph.D., et al., 16th edition, Lange Medical Publications, Los Altos, Calif., 1977; \$13.00.

Review of Physiological Chemistry is the 16th edition of a respected textbook published by Lange Medical Publications. Its multiple authorship is impressive, including Dr. Harold Harper, professor of Biochemistry, University of California School of Medicine; Dr. Victor Rodwell, professor of Biochemistry, Purdue University and Dr. Peter Mayes, reader in Biochemistry, Royal Veterinary College of London.

The intent of the book is to provide a reasonably concise presentation of those facets of chemistry most relevant to the study of biology and medicine. This reviewer believes that the authors have accomplished their purpose. The book contains some 648 pages, features numerous black-and-white charts, tables, and line drawings, has an attractive and sturdy, flexible, plastic cover, and the unusually low price of \$13. Your reviewer recommends it strongly for medical students and for physicians and members of the allied health sciences who desire a comprehensive reference book on biochemistry.

W. D. SNIVELY, JR., M.D.
Evansville

MEDICAL STATISTICS IN WORLD WAR II

Colonel John Lada, MSC, USA, editor, U.S. Government Printing Office, Washington, D.C., 1976; 1,215 pages, \$19.50.

This book is, indeed, a remarkable statistical volume which was derived from more than 18 million individual medical records. It covers the largest body of combat troops ever mobilized.

Part I covers a summary analysis and has four chapters concerning battle and non-battle admissions and selected diseases. Part II covers sources, definitions and methodology. Part III has many reference tables. In fact, there are numerous tables and charts for battle casualties, rates for non-battle disease and injuries, death rates by cause, etc. The printing is good and all illustrations are clear. The cost is reasonable.

This book provides a comprehensive reference and is invaluable to researchers, historians, teachers and students. I recommend purchase by all university and major public libraries.

WEI-PING LOH, M.D.
Gary

ARE YOU PROUD OF YOUR MEDICAL RECORDS? ☐ YES ☐ NO

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From THE JOURNAL 50 Years Ago

All along the line great strides have been made in prevention of disease because we have learned considerable as to the causative factors. Advancement in prevention will probably continue along the line of general medicine, for there is something tangible and definite to work upon. If the symptoms do not help us in discovering the cause, the history will. If neither are definite we can always have access to the autopsy and to the microscopic and clinical laboratory.

This is not true in mental sickness. The most frequent question asked us, and this question is always embarrassing, is "Why?" "Why is my husband insane?" "Why did my sister lose her mind?" We have seen the case; we have asked the usual questions; we have obtained a complete history and have had access to the laboratory, and we also have completed a neurological and psychiatric examination. Without much difficulty we have arrived at the diagnosis. The prognosis is not good. Then comes the everlasting question, "Why?" . . .

We are, in this paper, speaking only of the common types of insanity; of the manics, the paranoics, the praecoxes and the border-line cases in which definite cause is ruled out. In the paretics we have something definite to work upon. We know nothing definite, as yet, as to the etiology of most types of epilepsy.

It is very discouraging to review the literature as to the cause of mental sickness. . . . After considerable comment, the consensus of opinion is, "treat the original infection if the cause can be located, and hope for the best." As one author says, "In case of fever use an ice cap."

In fact, our investigation gets us nowhere. It simply brings us back to the original question, "Why?" . . . Ralph M. Funkhouser, M.D., Indianapolis, "Prevention in Some Types of Mental Sickness," JISMA, November 1927.

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION (Required by 39 U.S.C. 3685)

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2. Mail subscriptions	4,825	4,840
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FUTURE MEETINGS, SEMINARS, COURSES

Michigan Postgraduate Courses

The University of Michigan announces the following postgraduate courses, all of which will be held at the Towsley Center in Ann Arbor except the "Family Practice Update," which will be held at Boyne Highlands, Harbor Springs, Mich:

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Dec. 2	Care of the Burned Patient	Nurses, Other Health Professionals
Feb. 5-10	Michigan-Indiana Family Practice Update	Family Physicians
10-11	Topics in Adult Psychiatry	Psychiatrists
14	Sexually Transmitted Diseases	Family Physicians, Internists, Ob-Gyn
15-17	Urology Conference	Urologists
20-24	Emergency Medicine	Emergency Physicians

Complete information is available from the Department of Postgraduate Medicine, Towsley Center for Continuing Medical Education, Ann Arbor 48109.

Symposium on Medical Ethics

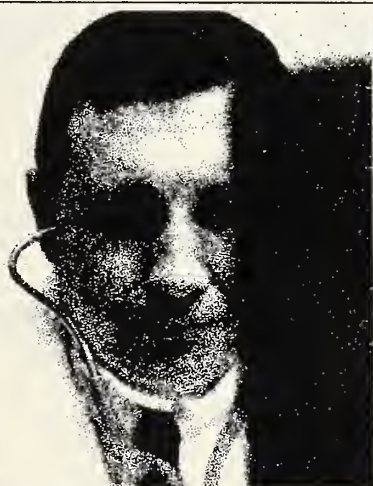
A course on "Medical Ethics" will be conducted Jan. 11 to 13, 1978, by the University of Kentucky and the University of Louisville. It will meet in the Galt House in Louisville. For details write Dr. Frank R. Lemon, University of Kentucky College of Medicine, Lexington, Ky. 40506.

Burn Symposium at Lexington

A Burn Symposium will be conducted by the University of Kentucky Feb. 1 to 4, 1978, at Lexington. Registration fee is \$75 for physicians and \$35 for nurses and physical therapists. For more details write Dr. Frank R. Lemon, College of Medicine, Lexington 40506.

High-Risk Patient Subject at NOGMA

The New Orleans Graduate Medical Assembly will meet in the Fairmont Hotel from Mar. 31 to Apr. 4, 1978. Scientific and technical exhibits are scheduled, together with a Clinicopathologic Conference. The theme of the session is "The High Risk Patient." Registration fee is \$200. It qualifies for CME credit in the AMA Category 1. Accreditation for the AAFP and the ACEP were granted for the meeting in 1977 and are being requested for 1978. Write Lois Neary, Executive Director, 1430 Tulane Ave., New Orleans 70112.



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Hospital Stays in Indiana Surveyed

Israel Praiss, M.D., and Philip D. Bonnet, M.D., of the Johns Hopkins School of Hygiene, have researched patient records of Indiana Blue Cross to determine "consistency of lengths of hospital stay for age groups and condition categories in practices of individual physicians." A summary of the results is as follows: Indiana Blue Cross data on 29,168 patients treated by 2,362 physicians in short-term hospitals during a one-year period (1967-68) are analyzed. Included in the study are patients with a single diagnosis and no recorded complications who were treated for one of five simple condition categories, i.e., hemorrhoids, appendicitis, hernia, cholelithiasis, and normal delivery. Out of the total of 2,362 physicians, only those with 10 or more patients in at least one condition category and providing services for two or more condition categories are included, i.e., 95 physicians (3.6%). Two hypotheses concerning the extent to which the performance of individual physicians is homogeneous and consistent are examined.

The results of this study seem to support the contention that individual physicians have a tendency toward a consistent pattern of providing patient care as indicated by their patients' lengths of stay. This pattern seems to be influenced neither by patient age group nor patient condition category.

Further studies applying similar methods to different populations under different medical care settings are recommended.

Certified by Nuclear Medicine Board

Dr. Jack Whitaker, Anderson pathologist who is director of laboratories and nuclear medicine at Community Hospital, has been certified by the American Board of Nuclear Medicine.

Hamlet Honors Dr. Leinbach

The community of Hamlet held an open house in August to honor **Dr. Earl R. Leinbach** for his 25 years of dedicated medical and civic service to the area. He has been a member of the American Academy of Family Physicians for 12 years and was elected a Fellow of the academy last year.

Hoosiers Host WHO Task Force

Representatives of nine countries were in Indianapolis in September for a three-day meeting of a World Health Organization task force on medical definitions. **Dean Steven Beerling** of the I.U. School of Medicine and **Dr. Robert van Hoek**, medical director of Wishard Hospital, were host for the WHO members. The group has met previously in Holland and Switzerland to try to set up worldwide definitions for irregularities of heart actions.

Union Hospital Honors Dr. Spears

Dr. Robert C. Spears, Terre Haute, received a sculpture created out of various surgical instruments when he discontinued his surgical practice recently. The gift was from fellow Union Hospital staff members and associates.

Governor Appoints Dr. Kissell

Dr. Wesley A. Kissell, Indianapolis, has been named by Governor Otis R. Bowen to the Indiana Board of Corrections.

Painting of Dr. Dillman Presented

Dr. Carl E. Dillman, Corydon, was presented with an oil portrait of himself at the annual picnic of the Harrison County Hospital staff recently. The portrait will be on display in the lobby of the hospital for a time. Each employee contributed to the fund to have the painting done. Dr. Dillman has been practicing in Corydon since 1935. Prior to his graduation from the University of Louisville School of Medicine, Dr. Dillman served the community as a teacher and principal.

Dr Sims Retires to Florida

Dr. J. Lawrence Sims, Indianapolis, retired from practice July 29 and has moved to New Smyrna Beach, Fla.

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Retires after 35 Years in Practice

Dr. Margaret Ann Bassett, Thorntown, was honored recently by members of the medical profession in Boone County and elsewhere throughout the state upon her retirement after 35 years in medical practice. Dr. Bassett is a charter member of the Indiana Academy of Family Physicians and was recertified just last year. She will remain in Thorntown.

Dr. Stoltzfus Elected to Fellowship

Dr. Glenn B. Stoltzfus, Goshen, was one of 567 physicians elected to Fellowship in the American Academy of Pediatrics by the AAP Executive Board recently.

Named Fairbanks Medical Director

Dr. Gerald P. Johnston, psychiatrist at Fairbanks Hospital, Indianapolis, has been appointed the hospital's medical director. Fairbanks recently was granted a two-year accreditation from the Joint Commission on Accreditation of Hospitals.

Dr. Gibson Heads Heart Association

Dr. Milton E. Gibson, South Bend, is the new president of the American Heart Association, Indiana affiliate, succeeding **Dr. Douglas H. White, Indianapolis**.

Dr. Ward "Outstanding Citizen"

Dr. Robert A. Ward, Tell City, was named Indiana's Outstanding Citizen recently by Governor Otis R. Bowen. The award was a part of a nationwide Outstanding Citizens Award

program to honor Vietnam veterans who have made contributions to their respective states. Dr. Ward served as an Army medical officer for four years in Vietnam, where he was assigned to the 596th medical company in a front line battle situation. Wounded once, Dr. Ward received the Purple Heart and the Bronze Star.

Reelected County Health Officer

Dr. James Sprecher, LaPorte, was recently elected to another term as county health officer, continuing him in the position he has held since the inception of the county health department in 1967.

Dr. Guy Owsley Announces Retirement

Dr. Guy A. Owsley, Hartford City, former president of the Indiana State Medical Association, has announced that he will close his practice Dec. 30. Active also on the local and national level in organized medicine, Dr. Owsley served as a delegate to the American Medical Association for six years and as a candidate for AMA vice president in 1971. He also served as president of the Delaware-Blackford County Medical Society. He received his M.D. degree from Indiana University in 1926.

Board Certifies Dr. Jason Park

The American Board of Psychiatry and Neurology recently certified **Dr. Jason Y. S. Park**, senior psychiatrist at Katherine Hamilton Mental Health Center, Terre Haute.

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NEWS NOTES

Continued

Upjohn Company Offers New Film

"A Short Physical Examination of the Articular System" is the subject of a new film recently released by the Upjohn Company. It outlines a complete but relatively simple examination of the musculoskeletal system as part of the annual physical checkup. To borrow the film, free of charge, write Professional Film Library, The Upjohn Company, 7000 Portage Road, Kalamazoo 49001.

Dr. Worth Attains Certification

Dr. Robert Milton Worth of the Section of Neurological Surgery, Indiana University Medical Center, Indianapolis, has been certified as a diplomate of the American Board of Neurological Surgery.

WAT 21 Presents "The Newborn"

The first Tuesday of each month (12 noon Indianapolis time) via WAT 21 Medical Television Indiana University School of Medicine will present "The Newborn," live broadcasts with informal two-way discussion. Dr. Richard Schreiner,

host for the program, anticipates interaction via the WAT 21 "talkback" phones with physicians, nurses and respiratory therapists in 34 Indiana hospitals regarding both the formal presentations and newborn care in general.

A bibliography listing relevant journal articles is available upon request; contact the WAT 21 station manager, I.U. School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

Mental Health Center Director Named

Dr. Borivoj S. Divcic, Valparaiso, has been appointed medical director of the community mental health center in Valparaiso. He joined the center staff in February 1976 as a staff psychiatrist and has served as acting medical director since July 1 this year.

Center Honors Dr. Sumner Furniss

The Indianapolis Sickle Cell Center, 3561 N. College Ave., was dedicated formally in memory of the late **Dr. Sumner Furniss, Indianapolis**, on Oct. 9. Dr. Furniss was the first Negro intern at Wishard Memorial Hospital, later serving four generations of Indianapolis residents as a physician.

TO OBTAIN ONE HOUR OF CATEGORY 5(a) AMA CME credit, answer the following quiz and return your answer sheet and application form to Division of Postgraduate and Continuing Medical Education, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46202

Indiana University School of Medicine certifies that this continuing medical education activity meets the criteria for one (1) hour of credit in Category 5(a) for the Physician's Recognition Award of the American Medical Association.

QUIZ

Hepatitis Antigens—Antibody Tests and Their Clinical Significance

(Pages 865-869)

SUCCESSFUL COMPLETION of this quiz will qualify the participant for one hour of 5(a) AMA Continuing Medical Education credit awarded through the Division of Postgraduate and Continuing Medical Education, Indiana University School of Medicine. You will find the answer sheet and application form immediately following the quiz.

ANSWER THE FOLLOWING:

I. Which of the following are false?

1. Three types of hepatitis have now been categorized.
2. Differentiation of drug hepatitis from viral hepatitis is best done by liver biopsy.
3. Most chronic hepatitis is chronic active hepatitis.
4. Separation of the carrier state, chronic persistent and chronic active hepatitis can be accomplished by history, physical and laboratory findings.
5. Only chronic active is usually treated (with steroids).

II. The discovery of the HB_sAg has resulted in:

1. Establishing regular gamma globulin as the preferred method of prophylaxis for appropriate contacts of HB_sAg positive patients.
2. Decreasing post-transfusion hepatitis by at least 25%.
3. Distinguishing the single type of hepatitis which needs only needle isolation.
4. Diagnosis of a type of acute hepatitis which remains HB_sAg positive for six months after the clinical episode of hepatitis.
5. A type of hepatitis that can be transmitted by "intimate" contact.

III. Which of the following are true with regard to HB_sAg positive patients?

1. HB_sAg positivity is usually found only at the peak of the SGOT elevation in acute cases.
2. All HB_sAg positive blood when transfused will result in hepatitis.
3. The e-antigen/antibody system holds promise of defining which HB_sAg positive patients are ineffective.



4. The a, d y w r Systems help define whether chronic hepatitis will occur.
5. When the serum becomes negative to HB_sAg, anti-HB_sAg regularly follows within a month.

IV. Match the appropriate letter or letters in the right-hand column that relate to the number in the left-hand column.

- | | |
|--|---|
| 1. HB _s Ag positive acute disease | A. Is primarily transmitted parenterally |
| 2. HA Ag positive acute disease | B. Australian antigen |
| 3. Non-A, non-B disease | C. HAA |
| 4. Chronic active hepatitis | D. Viral A hepatitis |
| 5. Rising anti-HA Ag titer | E. Persistently positive HB _s Ag |

V. Which of the following are features of Virus A hepatitis infection?

1. Need to have respiratory isolation.
2. Has a short incubation.
3. Can currently usually be diagnosed by a positive sera to HA Ag.
4. Usually needs hyper immune globulin for effective prophylaxis.
5. Has a true mortality rate of less than 0.2%.

VI. Which of the following are true for both Hepatitis A and B?

1. Stools are infectious.
2. Can easily result in chronic hepatitis.
3. Immunity to subsequent attacks of only individual specific types (i.e., no "cross" immunity).
4. Antibody to each is found with equal frequency in the U. S.
5. Active immunization to both is predicted in the near future.

VII. Answer TRUE or FALSE.

1. Non-A, non-B hepatitis is probably like HB_s Ag positive hepatitis.
2. Non-A, non-B is probably responsible for most of the HB_s Ag negative post-transfusion hepatitis.
3. Anti-HB_s Ag and anti-HA Ag presumably remain in the blood for many years after the respective infections.
4. Following clinical hepatitis a positive anti-HA Ag is good evidence that the disease was due to "infectious hepatitis."
5. A person is found to be HB_s Ag positive when going to be a blood donor. He can be just followed for at least a year unless he becomes symptomatic.

Complete this form to obtain verification for one hour of Category 1 AMA CME credit.

Answer the quiz on the answer sheet below. Circle the correct numbers or write the appropriate letter after the numbers. Then complete this form and mail it to Division of Postgraduate and Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46202. Your answer sheet will be graded confidentially, at no cost to you, and notification of successful completion of the

quiz will be forwarded to you for use with your application for the Physician's Recognition Award of the American Medical Association. For successful completion of the quiz you must answer 80% of the questions correctly. If you do not receive a notice advising you of your successful completion, you will know that you did not answer 80% of the questions correctly. Answers to the quiz will appear in a later issue.

Answer sheet for Quiz:

- | | |
|--------------------|-------------------|
| I. 1, 2, 3, 4, 5 | V. 1, 2, 3, 4, 5 |
| II. 1, 2, 3, 4, 5 | VI. 1, 2, 3, 4, 5 |
| III. 1, 2, 3, 4, 5 | VII. 1 |
| IV. 1 | 2 |
| 2 | 3 |
| 3 | 4 |
| 4 | 5 |
| 5 | |

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in a later issue of THE JOURNAL for my information.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

The Division of Postgraduate and Continuing Medical Education must receive your completed, signed application before Jan. 15, 1978, to be eligible for credit for this month's quiz. Answers to the quiz will appear in a later issue.

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BOOKS WANTED—History of Medicine in Indiana by Dr. B. D. Myers, published 1956; William Henry Wishard, A Doctor of the Old School, by Elizabeth Wishard, and One Hundred Years of Indiana Medicine, by Drs. Charles Combs and Edgar Kiser. Write or call THE JOURNAL: 317-925-7545.

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41st Annual New Orleans Graduate Medical Assembly March 31-April 4, 1978

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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MEDICAL MUSEUM NOTES



The portrait reproduced on this page was given to the Indiana State Medical Association a number of years ago by Dr. John Eric Dalton. He typed and glued his history of acquiring the painting to the back of the frame. It reads as follows:

The Story of this Picture:

During 1925-26 while assigned to the student OB service I strolled down Indiana Avenue. In a second-hand store, situated where Lockfield Gardens now stands, I noticed a grimy portrait of a man in an old gold frame. Being interested in antiques, I inquired about it. Through the dirt, I believed it to be probably a Lincoln picture, and I bought it for a dime. On cleaning it I was unable to identify the subject but found the name Dunlap written on the back.

Later I mentioned this to Dr. W. N. Wishard, Sr. and he directed me to bring it to him. When he saw it he believed it to be an early portrait of Dr. Livingston Dunlap. Still later he compared it with his photograph of Dr. Dunlap which was made at an older age, and he then identified it positively as the same man.

About that time Dr. Wilbur Peat, director of the Herron Museum, became interested in whether an early Indiana artist did the painting, however, it was not signed, and he was unable to identify it by technique. Nevertheless, he also compared the painting with the later photograph and regarded the two pictures as those of the same man at different ages. . . .

The photograph reproduced on the Medical Museum Notes page last month is the Wishard photograph of Dr. Dunlap mentioned in Dr. Dalton's narrative. The reader can compare last month's photograph with this month's portrait and come to his own conclusion as to

whether they are the same person. The similarity of clothing styles suggests that the difference in years between the portrait and the photograph is not as great as the difference in years of the two subjects depicted, and hence raises doubt as to whether the portrait is actually that of Dr. Livingston Dunlap.

Two of the Museum's 19th Century portraits are signed on the back rather than on the front. Since the portrait in question is signed on the back "Dunlap," and since Dr. Livingston Dunlap's eldest son, James, was an artist, the thought comes to mind that, regardless of the identity of the subject, the painting was possibly done by James Dunlap. It is also possible that the portrait could be that of one of Dr. Dunlap's other two sons. Such would account for the facial similarities noted by Mr. Peat and Dr. Wishard.

Twenty-eight years after examining this portrait Mr. Peat wrote a book entitled *Pioneer Painters of Indiana* (Wilbur D. Peat, 1954, Art Association of Indianapolis). He mentions James Dunlap in this

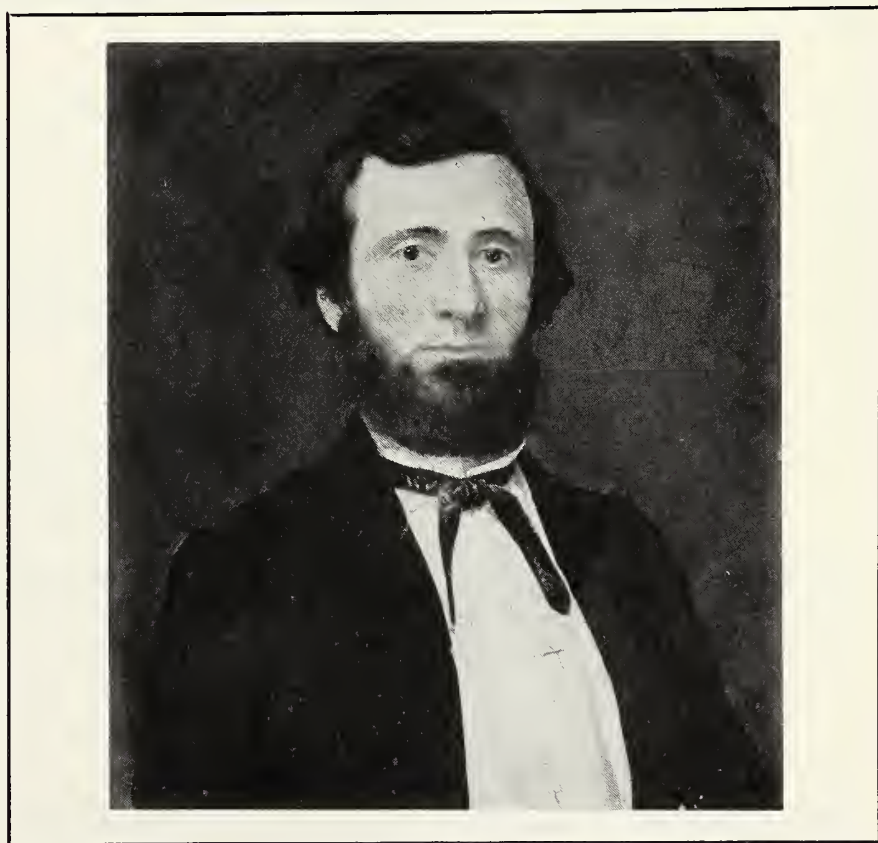
book. In summary his information is as follows:

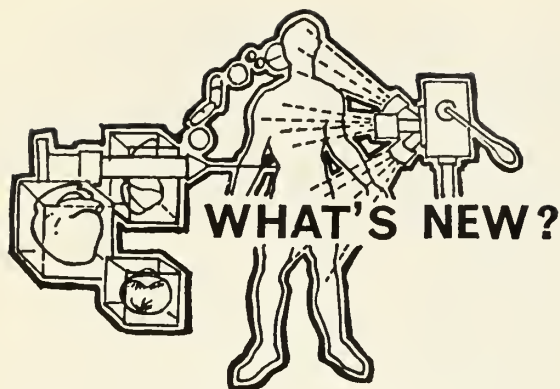
James Dunlap, 1825-1864. First commercial artist in Indiana. Did cartoons for the Indianapolis Locomotive. Advertised self as designer and wood carver, and artist of portraits and landscapes. Traveled West for his health (tuberculosis). Later turned to sculpture. Did statue of John Sutter, now in the statehouse. Did a statue of Lincoln in 1860.

In his book Mr. Peat indicates that only two portraits by Dunlap are known to exist. He reproduces one of these (plate 70, opposite page 172) which is remarkably similar in style to the portrait on this page. Unfortunately permission to reproduce plate 70 here could not be obtained.

Neither the identity of the artist nor of the subject of our portrait is established. Regardless, it originates from near the mid-nineteenth century and makes an interesting addition to the Museum.

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Derek, Inc., sells a highly efficient system for recovering metallic silver from x-ray developing solutions. It is called Electro-Lite. It delivers about 20% more silver than is extracted by outside services. High purity silver ingots are produced by an automatic process which operates on 110 volt current.

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahiglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Nipism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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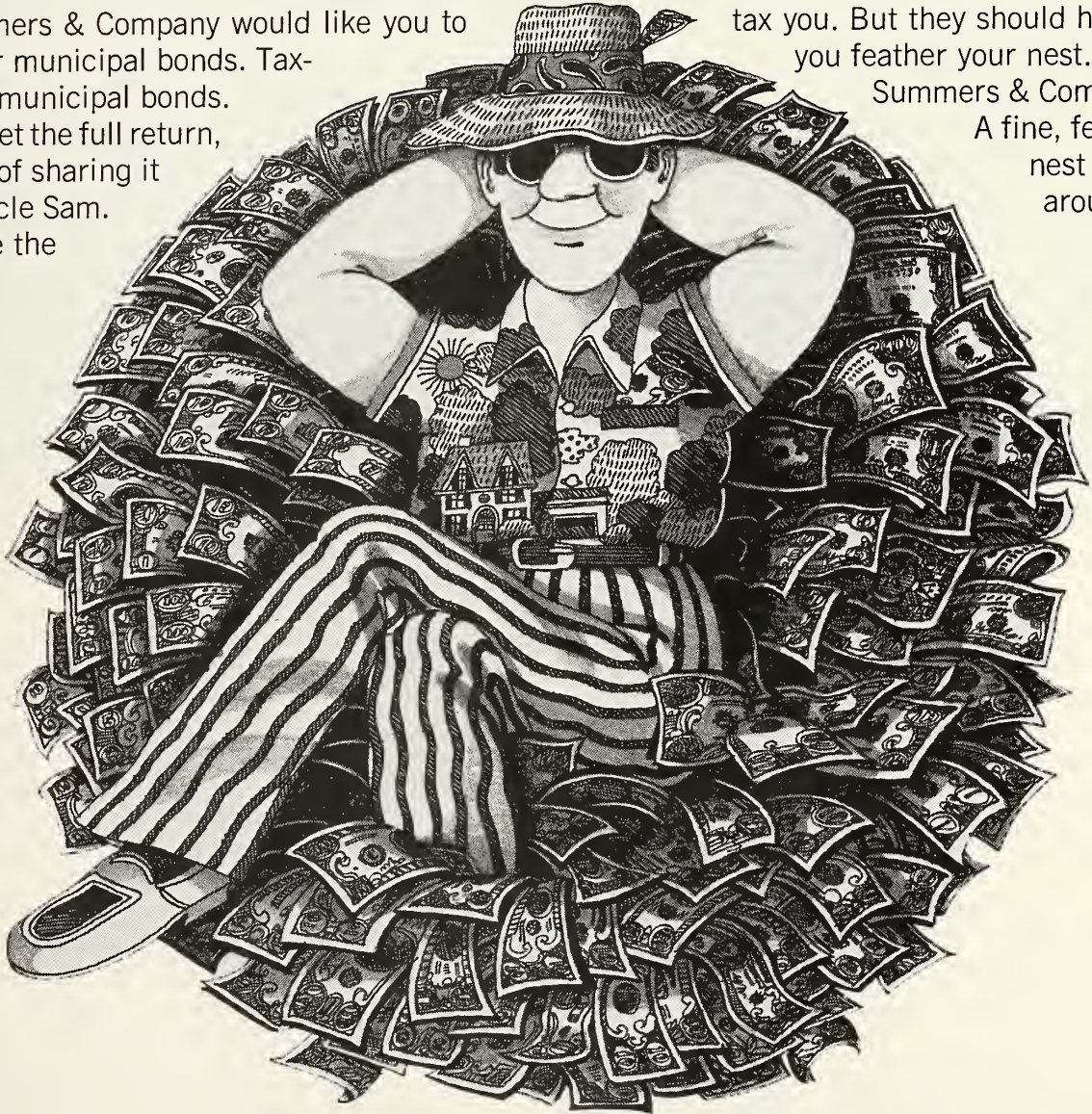
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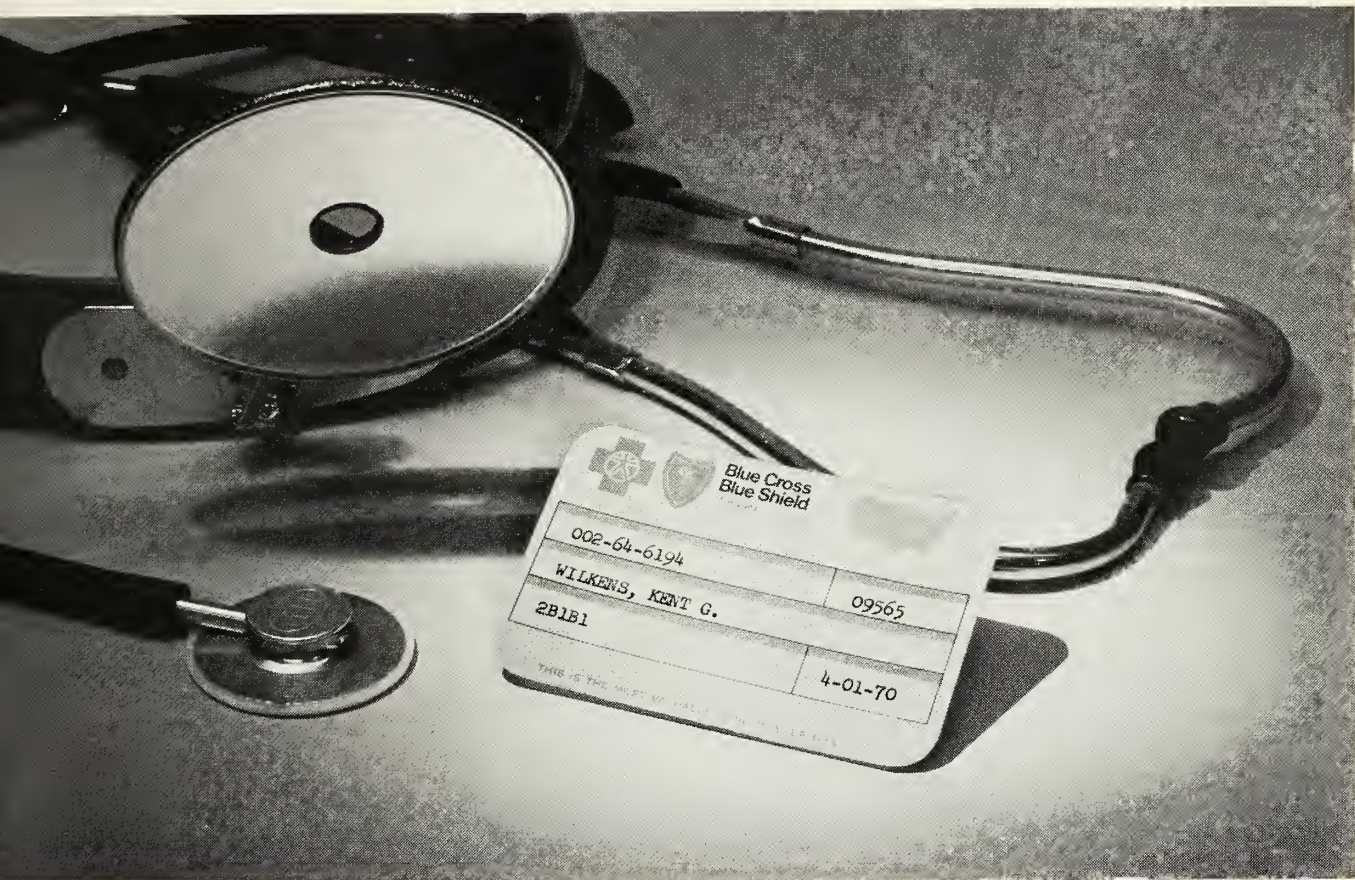
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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

PRESIDENT CARTER HAS SIGNED INTO LAW stiff penalties for providers who are found guilty of fraud in the Medicare and Medicaid programs.

The new law levies felony penalties to a maximum \$25,000 fine and five years in prison, replacing the misdemeanor penalties of up to a \$10,000 fine and one year in prison.

The bill, passed overwhelmingly by Congress and sent to the White House, is aimed at providers and retains misdemeanor penalties for recipients convicted of defrauding the programs. It was the first major health bill of the Administration to become law.

Providers found guilty of fraud and abuse will be treated as felons and punished by up to five years in jail and/or a fine of up to \$25,000. Previous law considered such violations as misdemeanors rather than felonies.

Illegal "kickbacks" among providers are defined and institutions are compelled to submit ownership data to the government. One of the main targets of the bill was so-called "Medicaid mills" and kickbacks uncovered in several large cities.

The disclosure requirements do not apply to individual physicians or to groups of physicians.

States must form anti-fraud units separate from their health departments in order to qualify for Medicaid funding.

Other provisions:

****States can supersede PSRO activities covering Medicaid** if they demonstrate to the federal government that PSROs are making decisions that "have a detrimental effect" on state Medicaid spending.

****The Health, Education, and Welfare Department** was given the authority to select regional or national intermediaries if it concludes that existing intermediaries within a state are doing a poor job.

****Most Medicaid reimbursement** would have to be made within 30 days by the states.

An amendment giving HEW power to initiate suits was dropped from the measure by House-Senate conferees, but Rep. Paul Rogers (D-Fla.) said Attorney General Griffin Bell had informed him that the FBI was training 350 agents to audit Medicare and Medicaid records. Rogers is chairman of the House Commerce Subcommittee on Health.

Sen. Herman Talmadge (D-Ga.), chairman of the Senate Finance Subcommittee on Health, said the bill is a "clear, loud warning to thieves and crooks that will be heard in unmistakable tones."

Meanwhile, HEW Secretary Joseph Califano, told a television panel show that taxpayers are losing at least \$1 billion a year through payments to ineligible people. Califano denied reports HEW is abandoning "project integrity," declaring that 2,500 cases of provider fraud are being investigated on a state-by-state basis for possible prosecution.

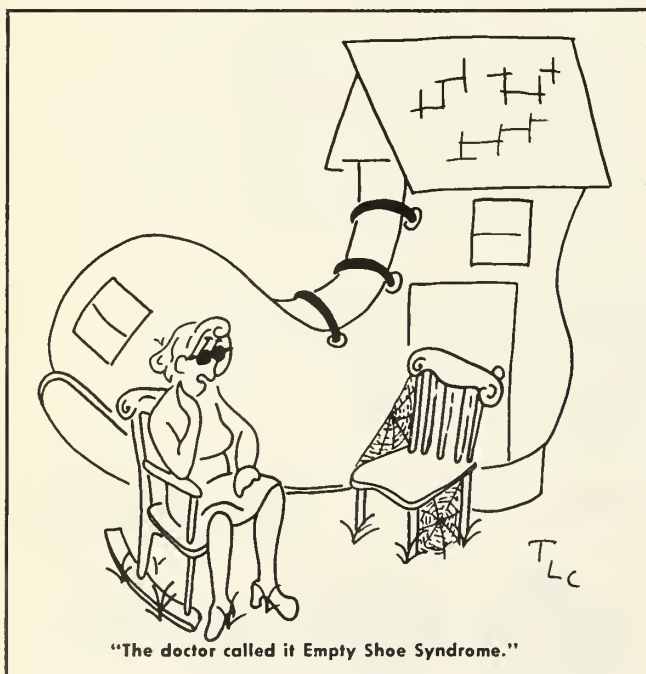
FINAL CONGRESSIONAL HEARINGS on the Administration's stumbling Hospital Cost Containment program have been conducted by the Senate Finance Committee and all indications are that no legislation will be enacted this year.

Subcommittee Chairman Herman Talmadge (D-Ga.) has said his information from the House side was that representatives are not "overly optimistic" the House will move before the end of the current session.

In an opening statement, Talmadge said he feared the Administration's proposed 9% "cap" on all hospital revenues could harm efficient hospitals. "Irreparable harm" could befall the hospital system, the senator said. "While there are many obese hospitals, there are many lean ones," he said. "I don't want to put all hospitals on a 1,200-calories-a-day diet."

Talmadge said his staff has drawn up a set of recommendations for an approach melding some of the Administration's ideas with Talmadge's own long-standing proposal for a thorough overhaul of Medicare and Medicaid hinging on prospective reimbursement for hospitals to encourage efficiency.

The first witness before Talmadge was HEW Secretary Joseph Califano who charged that if Congress delays passage another four months "there will be an additional inflation of \$2.8 billion in hospital costs. I must underscore again the enormous adverse impact on our health care system caused by continued delays . . ."



Continuing his assault on hospitals, Califano said many institutions "are wallowing in ice cream, candy and cake."

The American Medical Association told the subcommittee that a "cap" is "manifestly unfair" and would discourage hospitals from improving services. Robert B. Hunter, M.D., chairman of the AMA Board of Trustees, said the more admissions a hospital has, "the more likely it is to be penalized."

The bill includes medical equipment in physicians' offices under capital expenditure limitations when the cost is above \$150,000. This provision "is both unjustified and unsupportable," said the AMA witness. "Such a limitation would prove onerous, especially for physicians first opening practices as well as as for those desiring to modernize offices in order to assure continued quality patient care."

John Alexander McMahon, president of the American Hospital Association, told the subcommittee that the Administration bill "would seriously jeopardize the present and future ability of hospitals to provide quality care to the American people."

Applying a uniform cap on all hospitals "would exert the heaviest pressures where they are least appropriate—on the most efficient hospitals," said McMahon. These facilities would be forced to curtail essential services, according to McMahon.

THE CONGRESSIONAL INVESTIGATION of whether there is too much surgery has boiled down to a question of whose study to believe and whose interpretation is correct. Rep. John Moss (D-Calif.), chairman of the House Commerce Subcommittee on Oversight, insists there is far too much surgery, despite protests from many physicians and evidence from studies that his contentions are overblown.

Moss attacked the conclusions of a study headed by Ralph Emerson, M.D., president of the New York State Medical Society, that less than one percent of major operations are being performed with less than usually accepted indications.

Moss and his subcommittee have been relying on another study that 17% of surgery is not required, extrapolating that there are 2.4 million unnecessary operations yearly and 11,900 deaths from these procedures.

The Emerson study, underway since the late 1960s, used preset criteria for monitoring quality of surgical care, criteria prepared by four state medical schools, the state Department of Health and the state medical society. In addition to finding less than one percent of major operations questionable, the study found two or three percent of minor surgery in this category.

Karl Pfuetze, MD, a cardiologist from Kansas City and an expert on surgical statistics, testified that the so-called McCarthy study was employed erroneously by the subcommittee. The finding of a 17% difference of opinion on whether surgery should be performed stems only from the fact that there will be a range of from 10% to 20% of differing opinion for much elective surgery, said Dr. Pfuetze.

He said that if every surgeon sought the opinion of ten other surgeons on each case, there would often be one or two or three dissenters. But the majority judgment in such cases would be accepted. However, seeking these consultations separately for each case would result in a difference of opinion ranging from 10 percent to 30 percent.

C. Rollins Hanlon, M.D., director of the American College of Surgeons, said "The College recognizes the need to consider the complexity and cost of surgical procedures as well as the need for broad knowledge of surgical biology, diagnostic skill and operative skill to make the patient safe for the operation, and the operation safe for the patient."

Dr. Hanlon also told the Subcommittee:

"These needs dictate our continued insistence on long and exacting education for surgeons, rather than casual, on-the-job training, as inappropriate to modern surgery as the competence of the occasional weekend pilot to take over the controls of a 747. Scrupulously careful delineation of privileges based on

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education, peer appraisal of skills, and certification of specific competence will remain the most reliable basis for appropriately recommended and safely performed operations by genuine surgeons, rather than casual operators."

THE AMA HAS INFORMED SEN. EDWARD KENNEDY (D-Mass.) that it could not testify at hearings on competition in the health care field because the issues coincide with those posed at a trial now in progress before the Federal Trade Commission.

The hearing was called off by Kennedy. Among other witnesses slated to testify that day was Michael Pertschuk, FTC Commissioner. Kennedy planned to go ahead later with such hearings before an unusual joint session of two subcommittees he heads—Senate Human Resources Subcommittee on Health and the Senate Judiciary Subcommittee on Antitrust and Monopoly.

"For this reason," wrote AMA Executive Vice President James H. Sammons, M.D., "the Association has been advised by legal counsel not to appear to present testimony . . ." When an issue is involved in litigation, testimony on the same subject before Congress could jeopardize the legal position of the witness.

Dr. Sammons said that the AMA's stand on the primary issue of regulation and competition can be provided for the record. The Association has long advocated "a pluralistic system of health care with free competition among all practition-

ers whether practicing alone, in groups or as salaried or contracting physicians in HMOs" (Health Maintenance Organizations), said the AMA.

Kennedy also was informed that the AMA "strongly advocates" consumer information including standard fees charged by physicians. "The Association remains opposed to self-laudatory statements or claims such as testimonials and non-verifiable statements or claims."

The chief issue before the FTC is the AMA's code against unethical advertising by physicians.

Dr. Sammons said government regulation of the supply of physicians and their distribution by specialty "would have an unpredictable and detrimental impact upon the future quality of care."

The AMA letter continued:

"The issue of quality of care and cost of care are not separate and unrelated and are not independent from the issue of availability of services. These three elements of medical care are somewhat like a tripod in that alteration of one will cause an imbalance or instability of the other two.

A CONGRESSIONAL BUDGET OFFICE (CBO) study reports that non-whites are less healthy than white persons. Non-whites experience nearly 50% more bed disability days, 70% higher infant mortality and a life expectancy six years shorter than that of whites, the study said. ◀

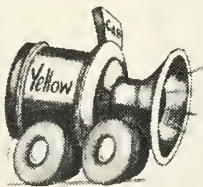


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From THE JOURNAL 50 Years Ago

1. It has been the purpose of the paper to discuss the present views concerning the treatment of hyperthyroidism. That is a difficult task because opinions are fast changing.

2. Hyperthyroidism due to toxic adenomata has almost universally been considered a surgical disease. The present tendency now is distinctly toward surgical treatment in the case of exophthalmic goiter.

3. The discovery of iodine by Plummer as a preliminary to surgery has made the surgery of exophthalmic goiter comparatively simple and much safer and accounts for the present tendency to surgery.

4. Medical treatment for exophthalmic goiter except as an adjunct to surgery is losing its enthusiasts. Physiological rest is the best medical treatment. Iodine is not to be considered a satisfactory treatment for exophthalmic goiter over a long period of time.

5. Radiation has some value in the treatment of exophthalmic goiter and Means is of the opinion it benefits toxic adenomata. The conservative radiologists are, however, not so enthusiastic concerning its use as they were. The Massachusetts General Hospital group now recommend surgery. Radiation should be tried in inoperable cases and in those that refuse operation although there are some objections to its use.

6. Bilateral resection of the thyroid gland under local infiltration anesthesia supplemented, if necessary, with gas-oxygen anesthesia is the present day popular treatment for hyperthyroidism.

7. It is important that the roentgenologist, internist, and surgeon continue to work together in these cases with an open mind hoping to solve in the future some of the differences of opinion that now exist concerning the treatment of this condition. . . . Cleon A. Nafe, M.D., Indianapolis, "The Treatment of Hyperthyroidism," JISMA, December 1927.

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A Review of 12 Years' Experience in the Surgical Management of 198 Ruptured and Unruptured Aneurysms of the Abdominal Aorta

ARA V. DUMANIAN, M.D.
HENRY A. HADIDIAN, M.D.
THOMAS F. WOODEN, M.D.
WALTER F. FLORCZAK, M.D.

Hammond

THE concept of resection of a diseased segment of an artery and the interposition of a homologous arterial segment to bridge the defect was first advanced by Gross in his treatment of 19 cases of difficult congenital aortic coarctation in October 1951. A few months later, in March 1952, Dubost reported the first successful resection and homograft replacement of an abdominal aortic aneurysm.

In the ensuing period excision and graft replacement of this lesion was rapidly accepted as the treatment of choice. Advances and refinements in the surgical technic, postoperative care and available

prosthetic materials have significantly decreased the operative mortality and morbidity associated with abdominal aortic aneurysmectomy. This extended the indications for aneurysmectomy so much that surgery is recommended for all patients that harbor an abdominal aortic aneurysm and are free of disabling medical illness or malignancy.

The purpose of this paper is to review our experience over a 12-year period in the excision and grafting of 198 cases of ruptured and unruptured cases of aneurysms of the abdominal aorta. An effort will be made to analyze and discuss a few other factors that have played an important role in the operative and hospital mortality.

The clinical material comprises a group of 198 patients operated upon for an abdominal aortic aneurysm at St. Catherine Hospital in East Chicago, Indiana, from Jan. 1, 1963, through December 1975 by the same group of surgeons. Ages of the patients ranged from 36 to 90 years with the largest group in the seventh decade of life. (Table 1)

The ratio of men to women was six to one. This ratio became 12 to one in the group whose abdominal aortic aneurysm had ruptured. (Table 2)

In 58 patients, or 29% of the total group, the aneurysm had either ruptured overtly (blood present in the retroperitoneal space and/or the abdominal cavity) or had extravasated into the wall of the an-

TABLE 1—AGE DISTRIBUTION

Age (years)	No.	Intact Aneurysm	Ruptured Aneurysm
30-40	1	1	0
40-50	5	5	0
50-60	49	40	9
60-70	90	66	34
70-80	50	36	14
80-90	3	1	2

TABLE 2—SEX DISTRIBUTION

	No.	Intact Aneurysms	Ruptured Aneurysms
Men	168 (85%)	110	54 (93%)
Women	30 (15%)	26	4 (7%)

From St. Catherine Hospital, 4321 Fir St., East Chicago 46312.

TABLE 2A—INCIDENCE OF RUPTURED ABDOMINAL ANEURYSMS

King's series	16%
Szilagy's series	17%
Gryska's series	18%
St. Catherine's series	29%

TABLE 3—MORTALITY RATES

	No. of Cases	No. of Deaths	Per Cent
Intact	140	16	11.5%
Ruptured	58	24	42%
TOTAL	198	41	21%

TABLE 4—MORTALITY RATES FOR THE TWO PERIODS

	1963-72	1973-75
No. of cases (overall)	107	91
No. of deaths	30	11
Percent	28%	12%

eurysm (the so-called "expanding" or "dissecting" abdominal aortic aneurysm). In King's series, 16% had ruptured. Szilagy reported an incidence of 17%. Gryska acknowledged an incidence of 18% and, in Vasko's series, 20% had ruptured. (Table 2A) In all likelihood, the above series included the cases with overt rupture only.

The hospital mortality following resection of an abdominal aortic aneurysm was 21% for the entire period. Table 3 illustrates the overall results. While 11% of the patients died when the resected aneurysm was intact, the risk of the operation was four times more when the aneurysm had ruptured.

When the results of the first 10 years of our experience were compared to those of the last three years, there was an impressive amelioration of the results and the hospital mortality went down considerably. During the past three years the hospital mortality following resection of an intact or rup-

tured abdominal aortic aneurysm has been 12%. (Table 4) The risk of the operation had dropped from 13% to 6% when an intact aneurysm was resected (Table 5) and from 60% to 32% when a ruptured aneurysm was resected. (Table 6)

Experience in the performance of the operation and refinements in the postoperative care undoubtedly constitute the basis for the marked improvements in the results. Experience translates often into skill and speed in surgery. In an effort to study this variable, the anesthesia records of all 198 patients were reviewed and divided into two groups, depending upon whether the resection of the abdominal aortic aneurysm had taken more or less than three hours. Mortality figures were obtained from each group. Of the group of patients that had an intact aneurysm, nine percent died following abdominal aortic aneurysmectomy when the surgery was completed in less than three hours, versus 19% when the surgery had lasted

TABLE 5—MORTALITY RATES FOR THE TWO PERIODS

	1963-72	1973-75
No. intact aneurysms	72	69
No. of deaths	9	4
Percent	13%	6%

TABLE 6—MORTALITY RATES FOR THE TWO PERIODS

	1963-72	1973-75
No. of ruptured aneurysms	35	23
No. of deaths	21	7
Percent	60%	32%

TABLE 8—MORTALITY RATES

	No. of Cases	Deaths	Percent
Iliac Arteries			
Normal in Size	134	22	16%
Iliac Arteries Aneurysmal	65	19	29%

longer. (Table 7) In the group that had ruptured their aneurysm, the speed in the performance of the operation played a very important role. The mortality figure dropped from 55% to 26% when the resection of the ruptured abdominal aneurysm was done in less than three hours.

Experience undoubtedly allows the surgeon to resect an abdominal aortic aneurysm, whether intact or ruptured, with speed. However, the severity and the extent of the pathology may also influence the speed of the performance of the surgery. The more extensive the pathology, the longer it would take to repair it. The role played by the severity of the disease was studied in two ways: First, the operative reports were analyzed to see whether the iliac arteries were normal in size or aneurysmal. Second, whether a straight or bifurcated graft was used following the resection of the abdominal aortic aneurysm.

Table 8 gives the mortality rates for the entire series, whether or not there was a concomitant iliac artery aneurysm along with the abdominal aortic aneurysm. When there was no aneurysm of the iliac arteries, 16% of the patients died following

TABLE 7—MORTALITY RATES

Time in Surgery	Overall Group		Intact		Ruptured	
	No.	Deaths	No.	Deaths	No.	Deaths
Less than 3 hrs.	128	16 (12%)	102	9 (9%)	27	7 (26%)
Longer than 3 hrs.	60	19 (32%)	38	7 (19%)	22	12 (55%)

resection of the abdominal aortic aneurysm. This figure rose to 29% when there was a concomitant iliac artery aneurysm.

It usually takes the surgeon less time to resect an abdominal aortic aneurysm when he can save the bifurcation of the aorta and use a straight tube prosthesis. Thus, when an abdominal aortic aneurysm is localized, the risk of its resection becomes less than where a bifurcation graft is used, as can be seen in Table 9.

TABLE 9—MORTALITY RATES			
	No. of Cases	Deaths	Per-cent
Straight prosthesis	44	6	14%
Bifurcated prosthesis	154	32	21%

Conclusion

At St. Catherine's Hospital resection of an intact abdominal aortic aneurysm in the past three years has carried a risk of six percent. The mortality rate for the same period has been 32% when the aneurysm had ruptured. Improvements in surgical techniques, prosthetic material and postoperative care have translated themselves into improved

mortality rates. The time it takes the surgeon to do the resection as well as the extent of the pathology also play a very important role in the survival rate following resection of an abdominal aortic aneurysm.

Acknowledgment

My heartfelt thanks to my daughter, Tania Dumanian, for her excellent work in compiling the data. ◀

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Cancer Chemotherapeutic Agents

A new edition of this book by Dr. Irwin H. Krakoff is now available for distribution by the Divisions. This replaces the edition published in 1973.

In this publication, Dr. Krakoff gives up-to-date information on the use of anticancer drugs and describes the new agents. Also included in the presentation is a revised list of neoplastic diseases that respond to chemotherapy, results of treatment, response rates and survival times and a compilation of specific drugs available for the treatment of cancer.

Employing the Recovered Cancer Patient A reprint from the American Cancer Society's National Conference on Human Values and Cancer that was held in Atlanta in 1972.

The Employment of Persons With a History of Treatment for Cancer.

A five-page reprint from a publication entitled *Cancer*, vol. 33, no. 2, February 1974, by the American Cancer Society, Inc., J.B. Lippincott Company. This is a study that has been made by the Metropolitan Life Insurance Company, who reviewed its experience with employees hired in the past with a past history of treatment for cancer. Briefly, they concluded that the selective hiring of persons with cancer, in positions for which they are

physically qualified, is a sound industrial practice.

Another Spring—The Diary of a Radiation Patient. This pamphlet can be of great value to cancer patients who anticipate a series of radiation treatments and to the members of their families.

Oncology Nursing

The Professional Education Committee of the American Cancer Society, Indiana Division, Inc., is interested in forming a Nursing Subcommittee. Cancer nursing has many facets and an equal number of educational needs. Representatives are needed from all aspects of cancer nursing on a statewide basis—oncology nurses in hospitals and offices, chemotherapy nurses, those nurses involved in radiation therapy, visiting nurses involved with cancer patients, and anyone involved in cancer nursing education on an academic or clinical basis.

Objectives for the year are:

1. To identify nurses from around the state for involvement in cancer nursing education on a statewide or local basis.
2. To review and recommend use of American Cancer Society materials for nurses and student nurses.
3. To develop a Nursing Speakers Bureau.
4. To maintain liaison with other statewide nursing groups.
5. To develop and maintain an ongoing calendar of state and national meetings and programs in cancer nursing.
6. To plan Professional Education meetings for nurses on a regional and statewide basis.

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Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended, therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

Scabies

DONALD E. HAZELRIGG, M.D.
Evansville

SCABIES is due to infestation with the mite *Sarcoptes scabiei* var. *hominis*, commonly called the itch mite. Since the discovery of the mite in 1687, which marked scabies as the first disease of man with known cause, scabies has consistently ranked high in many studies concerning the incidence of dermatoses. For unexplained reasons, epidemics seem to follow 30-year cycles and are said to last 15 years. The current epidemic, which began in the 1960s in many parts of the world, should abate by 1979.^{1,2}

Organism

The adult female mite is approximately 400 microns in length with a central anterior mouthpiece and four pairs of legs, two anterior and two posterior, the latter ending in long bristles. The adult male is only about half as long as the female and the long bristles are absent on the fourth pair of posterior legs. Shortly after mating the female mite burrows into the stratum corneum of the epidermis, where it remains for its life cycle. Two to three eggs are laid each day, giving rise to larvae and nymphs. Mellanby, in a fascinating series of experiments, found the mean number of female mites to be only 11 with the most common site of infestation the hands and wrists.³

Clinical

Severe pruritis, often nocturnal, is the hallmark of scabies and initially exceeds the physical findings. Antihistamines may or may not give relief. Flesh-colored serpiginous burrows and papules are seen on the distal extremities. As secondary infection takes place,

crusts and pyodermatous changes become evident. Mites are most apt to be found on the fingerwebs, hands, distal extremities, nipples, penis and scrotum. In infants, the palms and soles are frequent sites of involvement.

Diagnosis

Direct methods of diagnosis include demonstration of organisms in a skin biopsy and microscopic examination of skin scrapings. Indirectly, one may establish the diagnosis with reasonable assurance if mites are found on people who have been in close contact with the patient. Many different technics used to diagnose scabies have been described in literature, including scraping with potassium hydroxide (KOH) or mineral oil, shaving the entire burrow, stripping with cellophane tape, extracting the mite with a needle and skin biopsy.⁴ The easiest method with the highest degree of accuracy is scraping with a scalpel blade and mineral oil. To scrape, one should apply the mineral oil directly to several unexcoriated lesions and scrape firmly with the scalpel blade. The material is then placed on a glass slide with a small drop of mineral oil in the center and

a cover slip gently applied to avoid air bubbles. The slide can be examined with the scanning lens of the microscope, looking for the characteristic mites, eggs and feces (scybala). Mineral oil is preferred over KOH for several reasons, the most important being: (1) the mites will float into the oil intact, alive and mobile, and (2) mineral oil will not dissolve the characteristic scybala or eggs.

Immunology

There is ample evidence that immunologic factors are most important in scabies. Since Mellanby's classic experiments it has been generally accepted that symptoms are due to sensitization of the host and, although the host may be infected, pruritis does not occur prior to sensitization.^{3,5} A second infestation produces an accelerated response with a shorter incubation period. After six months of infestation, intradermal skin tests with extracts of *Sarcoptes* organisms become positive in 24 to 36 hours, indicative of cellular mediated immunity. Recently, serum immunoglobulin IgA levels have been found to be significantly lower than normal and it has been postulated that the low serum level may correlate with low secretory IgA levels in skin secretions and, hence, may predispose to scabies infestation.⁶

Crusted Scabies

Crusted scabies, formerly called Norwegian scabies, is a severe variant in which literally thousands of mites are found on the skin of mentally or physically handicapped patients, patients of poor hygiene or immunosuppressed patients. Characteristic lesions are thick, adherent crusts under which large numbers of mites are found. Involved areas include the palms, soles, nails, ears,

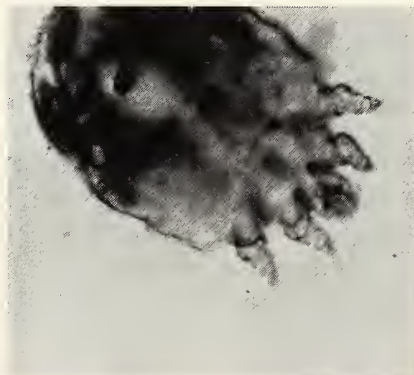


FIGURE 1. Adult mite with the central mouthpiece and four anterior legs in view. Note the small dark fecal pellet located posteriorly.

From the Section of Dermatology, Welborn Clinic, 421 Chestnut, Evansville, 47713.

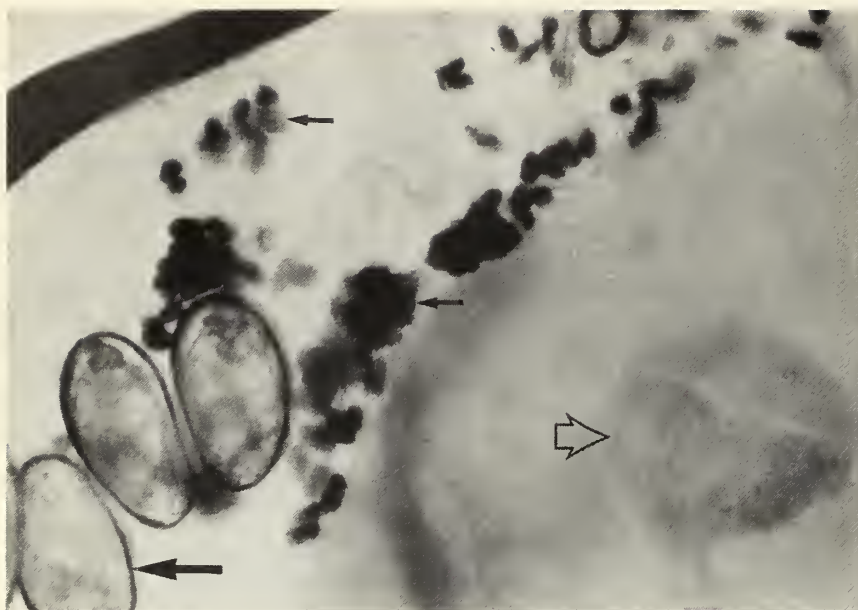


FIGURE 2. Three large oval eggs (large arrow), groups of dark fecal material (small arrows), and a small scabies nymph (open arrow).

elbows, knees, buttocks and scalp. Typical burrows are not seen and the patient usually does not complain of pruritus and does not scratch. Several large epidemics involving hospitalized patients have been described.⁷

Canine Scabies

The scabies mite has been found in a large variety of domestic and wild animals, including the horse, dog, cat, goat, sheep, cattle, tiger, lion and wolf.⁸ However, it is usually the ordinary household dog that transmits the mite to its unsuspecting master. Infestations are more frequent in puppies and frequently several members of the same litter are infested. Human infestations with canine scabies often occur in small epidemics. The lesions are most common on the forearms, chest, abdomen and thighs. The mite does not form burrows in the human host and mites are rarely demonstrated. However, mites may be demonstrated in scrapings from

the ear margins and intertriginous folds of the pet. Because the canine mite cannot propagate on the human host, canine scabies is self-limited.

Treatment

Gamma benzene hexachloride, the recommended therapeutic agent, is an extremely effective and safe scabicide available as a cream, lotion or shampoo.⁹ After a warm soapy bath the patient applies the medicine to the entire body surface with emphasis on certain locations. (See table) This may be repeated in three to five days as needed. However, initial studies showed a cure rate greater than 95% after one application. Other agents include crotamiton, benzyl benzoate, thiabendazole and sulfur in petrolatum. The latter has been recommended for treatments of infants and young children. Persistent pruritis may require topical or systemic steroids and does not necessarily indicate treatment failure or reinfection.

COMMON SITES OF INFESTATION

Hands, fingerwebs
Wrists, elbows
Breasts, especially nipples
Penis, scrotum
Feet
Palms and soles (infants)

Systemic antibiotics may be required for the secondary infection.

Summary

The present incidence of scabies is very high. Clinical evidence includes excoriated papules and burrows on the extremities and severe pruritus. The use of mineral oil in skin scrapings is an accurate technic for diagnosis. Gamma benzene hexachloride is the recommended therapeutic agent.

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Aphasia

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Introduction

It remains a rather difficult task for the physician to recognize aphasia and to evaluate it. In spite of numerous articles, aphasia is a subject slighted in medical training. It is the purpose of this paper to simply and cogently define aphasia, to teach how to evaluate an aphasic patient, and to interpret the evaluation.

Definition

Aphasia is any derangement of a person's ability to use language which includes the ability to comprehend or meaningfully communicate using the spoken or written word. Language depends upon two formal operations of the brain: (1) the ability to receive and integrate input into word images and (2) the ability to communicate outwardly in a way that corresponds to those images. These two operations are called, respectively, the receptive (receiving) operation (system) and the expressive (sending) operation (system). Depending upon which system is deficient, one will have either receiving or sending difficulties. These difficulties are called aphasia and can be classified as in Table 1.

Through expressive modalities, a person *sends* communicative output by way of the linguistic processes of writing (graphia) and naming objects (nomia) or by way of the non-linguistic processes of mathematics (calcula) or by way of pantomime behavior patterns (praxia). Through receptive modalities, a person *receives* communicative input by way of speech, reading (lexia), pictures (nosia), sounds (e.g., a bell sound means school is

to begin), and touching (stereognosis).

Clinical Signs

In a generalized and practical way, expressive functions are dependent upon the integrity of the left frontal lobe in the area just anterior to the lower third of the motor cortex. (Fig. 1) The receptive functions are dependent upon the integ-

rity of the posterior central areas of the left cerebral hemisphere in the area of the temporal parietal junction. (Fig. 2) It is evident that the great majority of people have *left cerebral dominance* in terms of language function regardless of the indicators as handedness, eyedness and footedness.

If a person sustains a lesion in the left frontal cortex (Fig. 1), he will have a hemiparesis but also an *expressive* aphasia. His comprehension of spoken language and his internal speech remain intact, but his ability to form appropriate words to express his internal word images is defective. He can usually follow directions but is unable to produce words verbally or by writing. Clin-

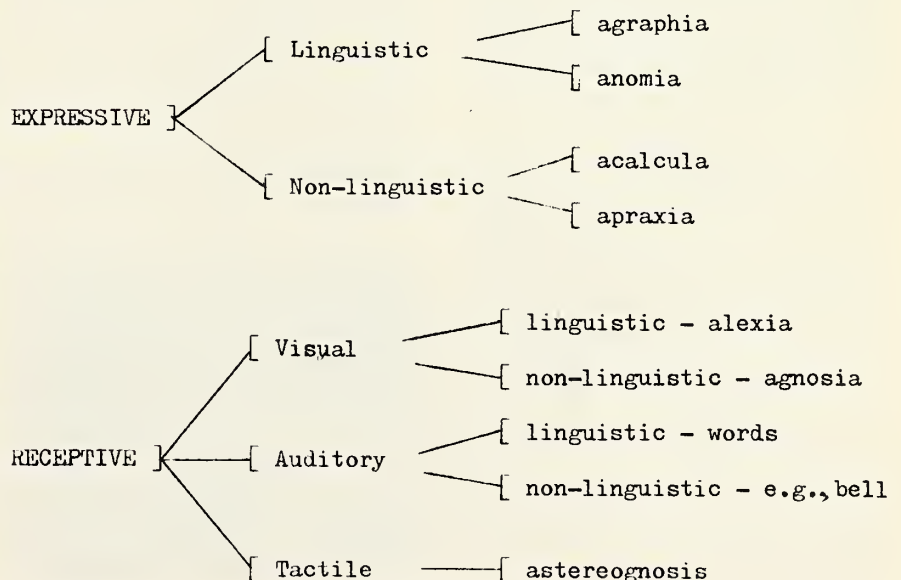


FIGURE 1. Lesion location of expressive aphasia.



FIGURE 2. Lesion location of receptive aphasia.

TABLE 1. CLASSIFICATION OF APHASIA



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ically, one would see someone who (1) speaks few words, (2) when he does speak, only a few stereotyped or repetitive responses are made, (3) follows directions indicating he understands what is said to him, (4) can read silently, (5) is unable to write, and (6) knows he is having trouble communicating, which is shown by signs of frustration and discouragement.

If a person sustains a lesion in the left temporal parietal area (Fig. 2), he will present a clinical picture representing *receptive* aphasia. The person's reservoir of word images remains intact, but his comprehension of the outside stimuli (speech) that evoke these images is defective. The person does not integrate the spoken or written word and cannot correctly follow commands. His efforts to produce language result in a fluent (clearly pronounced) but severely disordered, chaotic, meaningless array of irrelevant words, word fragments, simple sounds and, only occasionally, a complete phrase. He is unable to appreciate and understand the occurrence of his "word salad." Thus he may become annoyed with people when they cannot understand him and may jabber endlessly, forcibly and, often, pleadingly with those around him. Thus a person with receptive aphasia (1) speaks with many words, all disconnected, (2) cannot follow directions, (3) cannot understand what he reads, (4) is not aware of his deficit and (5) writes with many disconnected words as when speaking.

Evaluation

It is oversimplified to totally separate expressive and receptive aphasia since a complicated combination of both frequently exists. However, it does help clarify a difficult subject. Aphasia should not be confused with the disconnected bizarre sentences of the schizophrenic or delirious patient. There are also some brain disorders that make articulation difficult. Neither the meaningless and rambling though fluent word production of the receptive aphasic nor the near word-

lessness with some repetitive productions of the expressive aphasic should pose a problem. Minor aphasic defects may be missed in people where speech comprehension seems grossly normal. Slight mistakes in grammar, strange sentence construction, misplaced nouns, or a loss of the ability to describe things colorfully may indicate early aphasia.

The following protocol will help the examining physician evaluate a person for aphasia.

A. If the person cannot seem to speak sensibly, is it a fluent collection of words or phrases devoid of meaning? (If so, receptive aphasia.)

B. Is the person's speech constricted and limited to repetitive mouthing of a few words or phrases? (If so, expressive aphasia.)

C. Can the person follow simple verbal commands?

"Point to the ceiling."

"Walk to the door and turn around and bow."

"Make a fist."

"Open your mouth and stick out your tongue."

"Tear this piece of paper into three pieces."

(If fails to perform, then either receptive aphasia or expressive apraxia [understands command but cannot act it out].)

D. To check whether it is apraxia, set up a "yes" or "no" signal system, e.g., hand squeeze or head nod. Ask the following:

"Are you 110 years old?"

"Is today Christmas?"

"Is your hair blue?"

"Is this a _____?"

(If person responds correctly, then has expressive aphasia.)

E. Can the person write? (If he cannot, then expressive aphasia.)

F. Can he read an instruction silently and act it out? (If he cannot, then receptive aphasia.)

G. Can he read out loud and, if so, does his reading follow the text? (If he can read but not follow the text exactly, then has expressive anomia.)

H. Can he correctly select colors and pictorial items from a magazine

when asked? (If he cannot, then has receptive agnosia.)

A small pocket test booklet is also available to screen for aphasia in adults, as well as children. It is called the Halstead-Wepman Test and can be purchased for approximately \$15.00 from Publications Manager, University of Chicago Industrial Relations Center, 1225 East 60th St., Chicago 60637.

Prognosis and Treatment

The prognosis for an acquired aphasia in childhood may be better than in old age since the brain can be stimulated to recruit other areas for language function. This is not possible in the older person when cerebral vascular disease is usually the cause of left cerebral dysfunction. A large portion of the young victims with head trauma who have been in a temporary coma will have permanent mild aphasia, which is usually expressive in nature.

The treatment of aphasia is based upon the nature of the left cerebral lesion. Treatment is always difficult and the results guarded. Vascular occlusion causing infarction and traumatic situations are generally irreversible. Speech therapy and educational methods probably do not resolve aphasia but a trial of such therapy may be very supportive. The speech therapy may help the person make maximal use of the functions he has remaining and may help him circumvent his deficits. Family members and friends can be taught by the speech therapist to practice the drills at home with patient. The absence of significant progress within six months means a poor prognosis.

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Estrogens and Blood Pressure

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JEN years have elapsed since the first reports of the relationship between ingestion of oral contraceptives (OCP) and hypertension. Several studies have appeared subsequently indicating that this is not an unusual phenomenon and it has been reported in association with conjugated estrogens given for menopausal symptoms. In fact, among hypertensive females, contraceptive ingestion appears to be the most common form of identifiable hypertension. Initially, it was thought that the development of hypertension represented an idiosyncratic response to contraceptive ingestion in certain women. A careful search for characteristics of susceptibility, such as "toxemia" in a prior pregnancy, family history of diabetes and preexisting renal disease, failed to uncover a common predisposing factor. It has also been suggested that contraceptive administration may unmask a latency for hypertension, based on unknown genetic or environmental factors. Such a hypothesis does not appear to be subject to direct investigation in humans, but the high incidence of contraceptive-induced hypertension reported in an indigent, largely black population, a group in whom hypertension frequently occurs, would support that contention. A variety of studies related to the frequency of occurrence of hypertension during oral contraceptive therapy in previously normotensive women have yielded discrepant results varying from 1 to 19%. Some of the discrepancies may be explained by the small numbers of subjects in some studies, by the use

of homogeneous populations with differing susceptibility to hypertension, by variations in the definition of hypertension and by differences in duration of contraceptive administration. However, general agreement exists that hypertension can occur as a result of oral contraceptive ingestion. The entire clinical spectrum, from mild to malignant hypertension and renal failure, has been reported.

To assess the nature of the hypertensive response to oral contraceptives it is helpful to examine the observations of several large-scale prospective studies comparing women of similar age and race treated with oral contraceptives and mechanical contraception. One such study, involving 7,600 normotensive women, has been reported by the Kaiser-Permanente group. A progressive rise in systolic and diastolic blood pressure was noted in the oral-contraceptive treated group and the magnitude of blood pressure difference between the groups increased during the four-year study. Similar observations have been reported in a preliminary evaluation of a larger study of 46,000 women by the Royal College of General Practitioners in England. The latter study also has shown a 5% greater incidence of overt hypertension in the group treated with oral contraceptives in comparison

to the control group. A smaller study, involving careful blood pressure measurements in 325 Scottish women receiving oral contraceptives over a five-year period has disclosed a significant increase in blood pressure averaging 12.2 mm Hg systolic and 8.8 mm Hg diastolic. Thus, current evidence indicates that contraceptive steroids elevate blood pressure in normal women, but to a mild degree in most, causing overt hypertension in 1% to 20%, dependent on currently unidentified factors. Furthermore, when given to women with existent hypertension, oral contraceptives appear to raise blood pressure further.

Our further understanding of contraceptive effects on blood pressure has been enhanced by the identification of estrogens as the responsible component in the estrogen-gestagen formulations. In addition, it has been reported that the hypertensive phenomenon occurs in women treated with conjugated estrogens for menopausal symptoms. Indeed, even men are not safe from these effects, since I have observed three cases of malignant hypertension in men treated with diethylstilbesterol for prostatic carcinoma. Furthermore, cardiovascular complications associated with hypertension are frequently encountered in this group.

With the advent of lower-dose estrogen formulations it has been hoped that the effects on blood pressure would prove to be less. Unfortunately, ample evidence exists from early and more recent studies, utilizing vastly different estrogen doses, indicating that the blood pressure effects are not dose-related. However, as previously mentioned, the rise in blood pressure in



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normotensive women appears to be duration related. Overt hypertension has been reported to occur as soon as one to three months after beginning oral contraceptives or as long as after eight years of such treatment.

Obviously, the effective prevention, detection and treatment of the phenomenon of estrogen-induced hypertension would be made much easier by an understanding of the pathophysiology involved. Since estrogen-induced sodium and water retention has long been clinically recognized, it was natural that initial investigation of the mechanism involved in estrogen-induced hypertension be directed towards factors controlling salt and water balance. Thus, several studies of the renin-angiotensin-aldosterone system have been performed. Estrogens have long been known to increase the circulating levels of renin substrate, the precursor of angiotensin. For a given level of renin in the circulation, the immediate effect of an increase in substrate concentration would be to increase angiotensin II generation in plasma. This, in turn, would have two immediate effects: by directly acting on vascular smooth muscle to cause constriction, it would raise blood pressure; it would also act indirectly on the adrenal cortex to stimulate increased aldosterone secretion. This potent mineralocorticoid would then cause the distal renal tubule to increase its reabsorption of sodium (and water), leading to relative extracellular fluid volume expansion. The consequent volume expansion, if sufficient, could also raise blood pressure. In addition, sodium retention could sensitize the blood vessels to the pressor effect of angiotensin II and other vasoconstrictor substances and thus provide an additional increase in blood pressure. Fortunately, the normal physiological response to such changes favors homeostasis. In the above-mentioned perturbation of the

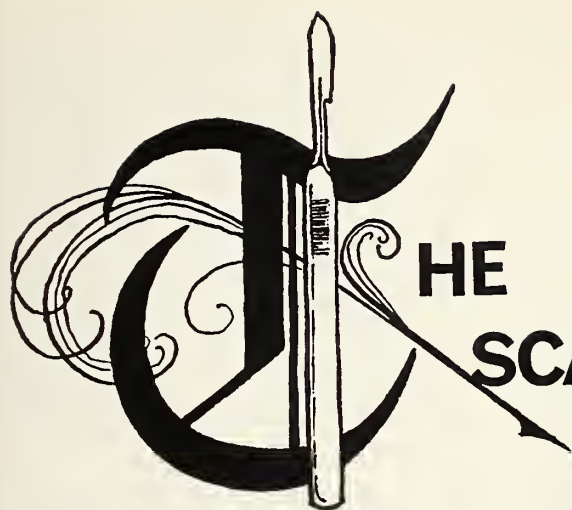
renin-angiotensin-aldosterone system by estrogens, homeostasis is normally maintained by reflex suppression of renin release by the kidney. This appears to occur by a direct feedback mechanism due to increased levels of angiotensin II in circulating blood, as well as indirectly by the ability of the juxtaglomerular apparatus governing renin release to perceive the alterations in sodium and volume status induced by the increased production of aldosterone. It was initially proposed that this feedback suppression of renin release may be impaired in some women when challenged by estrogens, resulting in hypertension. However, studies designed to evaluate this possibility have failed to reveal a consistent qualitative or quantitative difference in parameters of the renin-angiotensin-aldosterone system between hypertensive and normotensive estrogen-treated women. Thus, it would appear that changes in the renin-angiotensin-aldosterone system alone cannot explain estrogen-induced hypertension.

Certainly, many other factors are involved in blood pressure control. Hemodynamic factors include cardiac output and peripheral vascular resistance. Indirect factors include a variety of vasoactive systems, including the sympathetic nervous system, prostaglandins and the kallikrein-kinin system. Very few of these factors have been studied to investigate their participation in estrogen-induced hypertension. However, current evidence suggests that hemodynamic factors may be important. Walters and colleagues demonstrated an immediate increase in arterial blood pressure and heart rate (and presumably cardiac output), but no change in peripheral resistance after the intravenous administration of estrone or estradiol to normotensive women. In a subsequent study, the same investigators demonstrated increases in cardiac output, plasma volume and

blood pressure in normotensive women during six months of oral contraceptive ingestion. It is likely that the hypertensive response of some women to estrogens represents heterogeneity of physiological responses. It is hoped that future studies will clarify the mechanisms involved, permit identification of the susceptible woman and enable specific and effective prophylactic or therapeutic approaches.

Current knowledge indicates that estrogens raise blood pressure in normotensive women in a duration-related fashion. The long-term effects of mild blood pressure elevation in young women is not known, but discontinuation of estrogens usually results in a decline of blood pressure to control levels. Estrogens cause overt hypertension with the attendant clinical sequelae in a small but significant proportion of previously normotensive women. Furthermore, cessation of estrogen therapy over a period of 3-12 months results in a decline of blood pressure to normal levels in half of the hypertensive group. Estrogens are frequently taken by hypertensive women and make existent hypertension worse.

In view of these facts, it would seem prudent to monitor blood pressure at 3-6 month intervals in normotensive women for whom estrogens are prescribed as oral contraceptives or for the menopause. Prescriptions for such agents should be limited in time until normal blood pressure levels have been demonstrated. Blood pressure can be effectively measured by nursing or paramedical personnel. The occurrence of hypertension in a woman taking contraceptives or estrogens should mandate their cessation with frequent follow-up of blood pressure over several months. Pre-existent hypertension, renal disease and cardiovascular disease should constitute a relative contraindication to the administration of estrogens in any form. ◀



HE

SCALPEL AND THE PEN

VI. William Carlos Williams, 1883-1963

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WHEN Bill Williams was a youngster in Rutherford, New Jersey, he liked to run and run when playing with the neighborhood children until he lost them. He was then able to hide and think and, only then, return to the pack, perhaps a little triumphantly. Figuratively, this attitude can be thought to epitomize the later lifestyle of this famous poet who practiced medicine in his hometown for about 40 years. He did obstetrics and subsequent pediatric care of the infants he delivered. Although his obsession was the exegesis of ordinary America in prose and verse, especially the Passaic River region, as are the "Paterson" books, he was also in the mainstream of the sophisticated creative life which flowered after the Great War of 1914-18. His early and lifelong friend was the controversial poetic genius, Ezra Pound. Virtually all the new wave poets were his correspondents and confidants, including Marianne Moore, E. E. Cummings, Robert Lowell and Wallace Stevens.

His ethnic, cultural and social background was unusual and may account for his poetical inclinations. His father was an expatriate Englishman, raised in the West Indies, whose business interests took him to South America. Williams implies that his father and uncle were in some way illegitimate and related to

an aristocratic English family. The poet's mother was French-Spanish with a dash of Jewish blood and also from the West Indies (stated to be Puerto Rico and then at times, St. Thomas). She was a forceful Latin type who lived to 103. Williams says:

. . . Mother, who was known among her intimates as a medium, suddenly said to my father, looking right and left . . . 'So these are the boys. How they have grown. Come here, my dears,' she said . . . 'and let me see you.' This to her own children whom she had been caring for all day.

A heady environment of emotionality for a young fellow, although Williams negated this emotionality in later depictions of his childhood. His mother was an artist for a time in her younger years and lived in Paris prior to her marriage. She had been raised as a Catholic but, after marriage, the elder Williams were active in the Unitarian Church of Rutherford.

Nor was the charged psychological atmosphere confined to the distaff side, because his father's half-brother, Godwin, bearing, as Williams says, ". . . the secret name whose significance Grandma never

would divulge," developed symptoms of paranoid schizophrenia, attacked his nephew and presumably had to be removed from society.

Both Williams and his younger brother (by one year) were in school at Geneva and Paris for more than a year at the eighth grade level and then enrolled at the well-known Horace Mann High School next to Columbia University in New York. Williams profited by the progressive teaching and was able by special examination to matriculate at the University of Pennsylvania Medical School in 1902. Here, in the author's words is the reasoning behind his double career in medicine and letters:

. . . First, no one was ever going to be in a position to tell me what to write, and you can say that again. No one, and I meant no one (for money) was ever (never) going to tell me how or what I was going to write. That was number one. . . . Therefore I wasn't going to make any money by writing. Therefore I had to have a means to support myself. . . .

There may be an element of self justification after the fact here because he didn't make much money from his writing for many years. He did seem to have the classic motivation to doctor-work, that is as a means to bread and life. Forty years later, when asked why he continued

"Say it, no ideas but in things . . ."
—*Paterson*, Book 1, by the poet.



He deviated from Pound and Eliot later and considered them to be backsliders to the old European tradition while he, Williams, was trying to create in the *American* idiom. He prided himself, along with Wallace Stevens, on this point and was devastated when Eliot published "The Wasteland." He spoke disdainfully later of "Reverend Eliot" in an apparent aspersion on Eliot's Catholicism. He devotes an entire chapter in the "Autobiography" to Eliot's famous poem and writes:

These were the years before the great catastrophe to our letters . . . the appearance of . . . The Wasteland . . . which gave the poem back to the academics. . . .

Dr. Williams had a complex character full of flashing instinct and intellect, rebelliousness against formal religion and heightened sensuality. As he states in his life story,

I do not intend to tell the particulars of the women I have been to bed with or anything about them. Don't look for it. That has nothing to do with me. . . .

to practice medicine after he achieved fame in literature, he said that poetry and medicine were, for him, the same. His idea of the poem is that it partakes of creation just as an obstetrical delivery does for a doctor.

Amid all the writing, editing and corresponding of a literary person he handled a full case load. His creative spirit (and also his income tax) was buoyed up by everyday medical work. One year he was president of the Passaic General Hospital. Once, when trying to wind up his practice prior to journeying to Buffalo for a poetry reading, he had six expected deliveries for a nine-day period. He experienced chest pain in 1947 and had a cerebrovascular accident in 1951. Thereafter, he typed with one hand but the compulsion to "scribble" was unabated. Here is a quotation which sounds a familiar chord to fellow physicians in America (1949):

I sat in a smoke-filled room last night at a County Medical Meeting listening to two big boys talking about peripheral vascular disease until 11:30—and then a long drive home. I'm still groggy—but that's the way money is

made by yapping, yapping, yapping until someone pays attention to you. . . .

His literary career was initiated partly by his early acquaintanceship with the tempestuous intellectual, Ezra Pound. Through him he was introduced into the learned student groups in college. Pound went on to fame and was associated with the well known poet, T. S. Eliot. Later, for his activities as an expatriate American who espoused Fascism in Italy, Pound was tried and committed to St. Elizabeth's Hospital in Washington, D.C. as a mental case. Williams suggests that Pound's mental difficulties might have been caused by "befriending" a destitute street walker when yet a young man. It is difficult to ascertain from Williams' writings today if he meant that Pound was paretic, but it is clear that he remained on fairly good terms with Pound. Williams, of course, was much to the left of him politically. Pound initiated the introspective and introverted young Williams to advance-guard literature and perhaps was pivotal in directing the young medical student towards poetry.

He believed that the libido, as Freud says, is the force motivating all the actions of mankind. He married Florence Herman in 1912 and was openly devoted to her for the remainder of his life. His writing bears out his susceptibility to sexual emotions and he maintained an active interest in the opposite sex into old age. Nevertheless, he seemed to harbor no animosity against homosexuals. He met and admired Gertrude Stein and her house mate, Alice B. Toklas, in Paris in 1924. Altogether his was a conglomerate personality, which befits a poet. He was open and modern in his attitudes towards sex, which was the prevalent point of view of those creative young people of the 1920s who were his contemporaries. They can almost be said to have originated the sexual revolution and invented the "generation gap." He was, in a word, a man of his own time.

By 1912 his life was molded as it would remain for 40 years. He practiced medicine, emphasizing obstetrics, and wrote a little every day. The literary output over the years,

from his first privately printed book in 1909 to 1951 when his autobiography appeared, was at least 33 books of poetry and prose in print. This was before his stroke and retirement in the same year. Recognition was delayed and he was relatively unappreciated prior to World War II. His great long poem "Paterson" was finished but "Pictures from Brueghel and Other Poems" appeared in 1963. He received the Nobel Prize for this last and he died the same year.

An early poem entitled "On the Road to the Contagious Hospital" serves to epitomize his poetic consciousness and method. He tried to create as nature creates and not to mimic. Williams said:

There's nothing very subtle about the poem; all it means, as far as I know, is that in a waste of cinders, loveliness, in the form of color, stands up alive.

As a critic points out: The process is simply this: There is the eye, and there is the thing upon which that eye alights; while the relationship existing between the two is a poem.

He felt a mental kinship with the Irish novelist, James Joyce, who exploited the stream of consciousness narrative so effectively. He dealt with that Aristotelian idea of "epiphany," which, simply stated, is the soul of something presented clearly. Williams attempted this, for instance, in the short poem "Sycamore," where the very "treeness" of a tree is defined. Incidentally, Williams had a love of trees much as did those other literary doctors, Oliver Wendell Holmes and Anton Chekov. He tried, in the opinion of one critic, to achieve the three qualities of a beautiful work as defined by Thomas Aquinas—that is, uniqueness (*integritas*), then the process of cognition causing satisfaction and, finally, exposition of the essential nature of an object (*claritas*). He called his poetry "Objectivism" and said:

... The poem ... is an object ... that in itself formally presents its case and its meaning by the very form it assumes ...

Critical evaluation of his work becomes more favorable as the



years pass, with notable exceptions. Ivor Winters wrote acerbically that Williams was a "... foolish and ignorant man but at moments a fine stylist." It is certain that he cannot be easily understood by the casual reader today. Of course that can be said and more regarding James Joyce, the author of *Ulysses* and *Finnegan's Wake*, so this is no profound detraction.

What of the American spirit of William Carlos Williams? He had socially acceptable but somewhat "foreign" parents. It might be inferred that Williams cherished his country's ways much in the way of second generations even though he was an intellectual. Certainly he settled into suburban life in New Jersey with little complaint. This unyielding union with common American themes gives his work immediacy today much as that of William Hopper in art. Williams might enjoy the analogy. Williams was a romantic with realistic trappings. He must have had a fierce driving force to work so very hard at his dual professions.

His poem "Tract" was read at his

funeral in 1963. Here are a few lines from this parody of our attitudes towards the recently dead:

I will teach you my townspeople
how to perform a funeral ...

See! the hearse leads.
I begin with a design for a hearse.
For Christ's sake not black—
Nor white either—and not polished!
Let it be weathered—like a farm
wagon—with gilt wheels (this could be
applied fresh at small expense)
or no wheels at all.
A rough dray to drag over the ground.

Knock the glass out!
My God—glass, my townspeople!—
For what purpose—
to keep the rain and snow from him?
He will have a heavier rain soon:
pebbles and dirt and what not.
Let there be no glass—
and no upholstery, phew!
And no little brass rollers
and small easy wheels on the bottom—
My townspeople what are
you thinking of?

Williams, the young doctor, saw Spring arrive even in a desolate vacant area around the "Contagious Hospital" and these words defining new birth may close this study of America's poet-physician:

By the road to the contagious hospital
under the surge of blue—

All along the road the reddish
purplish, forked, upstanding, twiggy
stuff of bushes and small trees—
Lifeless in appearance, sluggish
dazed spring approaches—

They enter the new world naked,
cold, uncertain of all
Save that they enter. All about them
the cold, familiar wind—

One by one objects are defined
It quickens: clarity, outline of leaf
But now the stark dignity of
entrance—Still the profound change

has come upon them: rooted they
grip down and begin to awaken.

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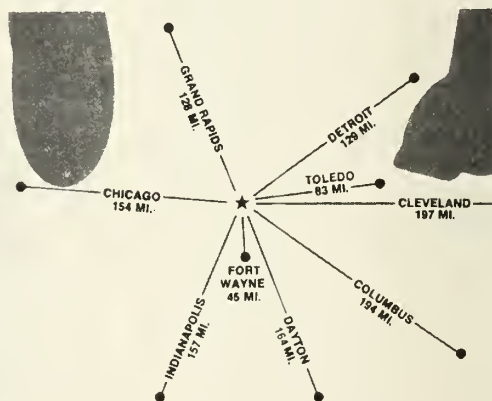
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The Royal College of Surgeons of England

AUSTIN L. GARDNER, M.D.
Indianapolis

Opening a journal for study or casual reading often results in a warm feeling of recognition of a subject recently encountered or an author of note.

This certainly adds interest to the time spent and when encountering the Watson-Jones lecture of 1976 by George Bonney of St. Mary's Hospital on Some Lesions of the Brachial Plexus, interest was fired for many reasons but most because of a recent personal case. Mr. Bonney, after paying proper respect to Sir Reginald Watson-Jones and bemoaning the degradation of the National Health Service and the "eroding of influence of Watson-Jones's ! No More McKees! Charnley No More!" undertook a brief review of entrapment, tumors and injuries of the brachial plexus. The effort was masterful, a most interesting variant from the generally accepted management was the attitude of the aggressive approach to the injuries of the plexus for reasons other than prognosis. He advocated looking at the nerves as soon after injury as possible, and outlined interesting clinical and laboratory means of evaluation.

A 90th birthday tribute to the honorary librarian of the Royal College of Surgeons, Sir Geoffrey

Keynes, revealed a giant of an academician, whose most outstanding contribution would seem to be his evaluation of the work of William Harvey and the restoration of John Hunter's museum. His capability in thyroid surgery led Selwyn Taylor to consider him supreme in his field. It would be difficult to find a surgeon senior to an active 90-year-old, but Dr. Goethe Link would not confirm or deny Mr. Selwyn Taylor's appraisal.

The advancing frontiers of oesophageal (as it is spelled) surgery is considered by Mr. Richard H. Franklin, pointing out his approach to the esophagus through the right side of the chest and the importance of early anastomosis.

An evaluation of cryosurgery of the prostate by Mr. Alan Green of Norwich resulted in the recommendation of its use as a secondary procedure.

An excellent review of the surgical anatomy of the aponeurotic expansions of the anterior abdominal wall by Professor Askar of Cairo points out anatomical reasons for functional differences in the upper and lower abdomen which were suggested many years ago. He even explains the reason for a "potbelly."

The Arris and Gale lecture was

first delivered in 1694 by Clopton Havers, for whom the Haversian Canals were named. Mr. Sean Hughes assessed the activity of technetium EHDP in tumors and fractures and concluded that uptake was related to blood supply. No reference was made to Dr. Clyde Kernik's work on the origin of the healing bone cell.

The Vicary lecture of 1976 by J. R. Kirkup of Bath was delivered on the 300th anniversary of the publication of Richard Wiseman's "Severall Chirurgical Treatises." Mr. Kirkup has carefully reviewed the case histories left for posterity on subjects of tumors, ulcers, diseases of the anus, Kings' Evil, gunshot wounds and venereal disease. His observations were direct and honest. For instance, he describes forgetting to remove a tourniquet after amputating an arm, and differentiates the superficial from a deep burn in an accidentally self-inflicted burn on Guy Fawkes Night. He was a contemporary of Thomas Willis and Richard Lower. His period was described as the "age of individual scientific endeavor." The accomplishments were prestigious—Galileo, Harvey, Boyle, Malpighi, and Newton—an exciting time. ◀

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Stabilizing Health Care Costs

A cost containment program on a voluntary basis has been initiated by the American Hospital Association, the Federation of American Hospitals and the American Medical Association.

The program is to be oriented to cost control not only for hospital care but will include health care as well. The three great associations issued a joint statement to launch the campaign and to solicit the formation of similar endeavours at state levels.

A national steering committee will be organized to include hospital people, doctors, insurers, consumers and any others with a major interest in the project.

The incentive underlying the joint action is the belief that voluntary restraint by hospitals and doctors is the most equitable method to achieve effective cost containment consistent with sound medical practice and with the least disruption to patient care.

The national steering committee will be instructed to keep the Congress, the Administration and the public informed as to activities and progress of the committee.

As a matter of fact, it is not difficult to devise a plan for stabilization of medical care and hospital costs. All we need to do is to prohibit all advancements in medical care, to cease all medical research

and to stabilize the cost of all goods and services. This is, of course, a large order, and one not likely to be accomplished, but it is the only method of lowering costs without lowering quality of care.

"It's Good for You" Isn't Good Enough

HABIT is a powerful force in the choice of food. Dietary changes are difficult or impossible unless backed up by very persuasive motivation.

A recent eight-week experiment to determine how health is affected by a high fiber diet demonstrated to the participants that the test food was beneficial. However, only one third of the dieters continued to eat the cereal which was the subject of the research.

Dr. Martin H. Floch, professor of medicine at Yale University, conducted the study and concluded that, if better permanent results were to be obtained, behavior-modification techniques would be necessary and the test food would have to be more appetizing.

This is especially true in preventive diets. Patients who have demonstrable and symptomatic disease find it difficult to modify eating habits; well people almost never alter the diet, despite promises of future advantage.

During World War II the U.S. Army diet was the same all over the

world regardless of climate. After the war dietitians devised an ideal diet for tropical use and another for arctic conditions.

Careful measurements were made of the nutrients which soldiers in the field under tropical and arctic environment obtained from the special rations and from the standard "back-home" ration. In all instances the G.I.s got more essentials from the standard diet than from the ideal diets. The reason was that they consumed more of the diet to which they were accustomed. They were actually nourished better by the standard ration because of failure to eat adequate amounts of the unfamiliar but theoretically better diet.

The experiment at Yale has convinced the researchers that, in devising dietary changes for the benefit of the gastrointestinal tract, the newly added food must be high on the palatability schedule—no one in apparent good health will switch to less appealing dietary preparations for very long, no matter what the expected benefit.

Behavior modification techniques will work only in situations in which the results are apparent immediately, such as control of weight, cessation of smoking, alcoholism and chronic pain. Motivation depends on a benefit which is soon obtained. This is what is lacking in a program of dietary change for prevention of ailments such as diverticulo-

sis. Here the benefit is not only a long way off but it also may, and often does, consist of an absence of disease, an end-point which is very difficult to appreciate.

Guest Editorial

If the Decision Were by the Sick

THE increase in cost of medical care is consistent with increase in cost of most other major parts of our economy—food, gasoline and housing, etc. But the physicians know that this is not the real issue. The fact is, the cost of medical care should not be addressed the same as other costs. There are some things that cannot be measured in dollars—as we learned at our mother's knee.

Take the hallmark of the present debate on cost containment—the CT scanner. What is the cost of two or three days' wait, or longer, for examination by one of the limited numbers? It is not only the hospital per diem! It is not only the occasional cost in life where immediate examination could have been lifesaving. An immeasurable cost of delay is the worry and agonizing of the patient until the diagnosis is made.

Every patient wants the best. But this fact is not the prime concern of the health planner who makes his decision by numbers and statistics. This fact is not appreciated by the bureaucrat of HEW whose personal health care is guaranteed. This is not a worry of Senator Kennedy and the authorship of NHI whose financial position has always assured that there be no wait for the best there is.

Perhaps the decisions on cost of medical care should be made only by those who have been seriously ill. Such decisions would be to the advantage and deep appreciation of those who are yet to be sick.—**Carl H. McLauthlin, M.D., editor, Rocky Mountain Medical Journal, September-October 1977. Reprinted with permission.**

Editorial Notes . . .

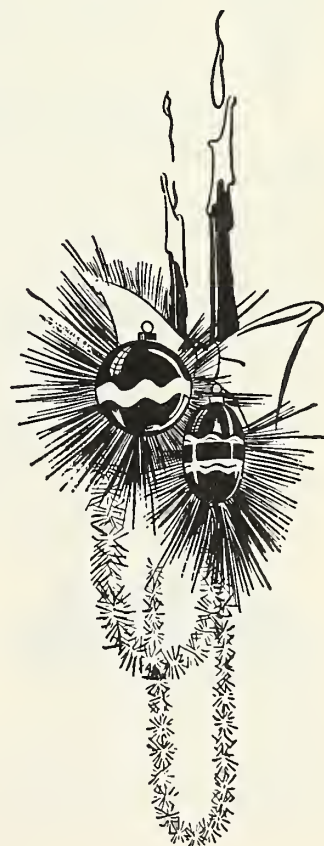
It may now be possible to produce sustained protection against virus infections. Interferon molecules are small soluble proteins produced by an animal's cells when they are attacked by viruses. These molecules do not appear to protect the cells that produce them but may stimulate the uninfected cells to synthesize substances which make those cells resistant to viruses. Upjohn researchers are still in the midst of the small animal research of such a process and are now looking for a compound which will function as a interferon inducer.

Results of a study by the VA, published by the NEJM, on the results of coronary bypass operations are attracting attention in the news media. The point, made without any determination of whether coronary anginal pain was relieved, was that the patients who were operated upon lived the same length of time as another group with the same diagnostic findings who were treated medically. In the case of patients with severe angina who are operated upon only after medical treatment has failed to control the pain, and who obtain relief, the question of how long they live is beside the point. Most patients would choose to live the same length of time without anginal pain; it is the quality of life that counts. If the operation accomplishes this, that is it.

John B. O'Day, president of the Insurance Economic Society of America, has testified to DHEW that a government takeover of health insurance and health delivery systems will create a tax burden the American people could not afford to pay. A 20-year-old worker 30 years ago paid a maximum of \$30 for Social Security. Now at the age of 50 his tax is up to \$965. He predicts that workers will pay over \$2,500 in Social Security taxes by 1990. He estimates that health care

will cost \$223 billion in 1980 without national health insurance, and another \$25 billion will be added by NHI, if it is adopted.

Representatives in Congress make a great thing out of the reputed attention they assertedly give to the opinions of the voters back home. Whether congressmen really pay attention or not, it is hard to determine how so much interest is generated in Washington for national health insurance. The latest Gallup poll shows that a great majority of Americans, including the elderly and rural residents, believe they receive high quality health care. They are well satisfied with it and are not worried about financing it. Over half of them feel they could meet the costs of a major, long-term illness. Some were in favor of national health insurance because they thought it would be "free"—when told taxes would be increased to pay for NHI most lost their enthusiasm.





BOOK REVIEWS

THE DOCTORS' AND PATIENTS' HANDBOOK OF MEDICINES AND DRUGS

Peter Parish, M.D., Alfred A. Knopf, New York, 1977; \$12.95, \$5.95 in soft cover.

This publication is the most unusual and informative documentation I have ever read. The basic purpose is to bring to the Medical Profession and the lay population a compact and comprehensive evaluation of the choice, use, effects, toxemia and side effects of the drugs most commonly used in treatment of illnesses as seen today, regardless of the area of practice.

I believe the most neglected study in medical schools today is in therapeutics. The practicing physician today has a very limited scope of the drugs on the market today and the drugs used by each doctor are those which he has become accustomed to prescribing. This book meets the need for a quick reference source.

The basic principle of drug use is the substance most fitted to alter the structure or function of the living organism which has been changed by disease. Practically everyone is exposed to air pollutants, pesticides, vitamins, alcohol, tobacco (even a non-smoker) and foods which often change the individual's life style and necessitate medical help. The medicines used to correct an abnormal state are selected because they possess or are thought to possess useful properties. They are used to relieve physical or mental symptoms, to produce an altered physical state, in hopes of an improvement or cure.

Dr. Parish has in this publication covered the subject thoroughly and has a complete survey of the problem in three parts: Part One: Basic Principles of Drug Use. Part Two: Groups and Types of Drugs. Part Three: Pharmacopeia.

Part One is most interesting and informative, in that the drugs used in the daily practice of medicine are considered with special emphasis toward the physiology—that is—the administration, absorption, distribution, biotransformation, elimination, adverse effects, interaction between drugs, vulnerability to drugs, dependence on drugs and a good evaluation of the practice of over-the-counter dispensing of drugs. This type of procedure does have a place in the minor ailments which do occur but should be controlled by the doctor or the pharmacist rather than self treatment by the patient in order to save money by avoiding good medical care.

Part Two describes the group and types of drugs. This is a complete and comprehensive study of the drugs used in treatment of the daily complaints as noted in the practice of medicine. The 186 pages devoted to the study of the various drugs which are available for the treatment of various illness is fantastic. I have never had a review of physiology, anatomy or therapeutics and its application equal to that in this publication.



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Part Three. In this section the drugs (1,100-plus in number) are listed in alphabetical order by their brand name and by their generic or chemical names. The list includes both the most frequent prescribed drugs and the most common non-prescription drugs used. The arrangement is such that any drug in question is well-documented and the detailed description of effects, adverse effects, precautions and dosage is found under the entry for that drug, which is readily accessible and all pertinent information is available at your fingertips. The 159 pages applicable to the drugs which are now in daily use, including the experimental drugs in various hospitals and clinics, are noted in this publication and in a simplified but adequate detail to permit the physician to review the drug in its entirety.

The author has stated that this book is both for the use of the medical profession and the lay person but I question whether the information given (which is excellent) should be placed in the hands of the average patient.

I enjoyed reviewing this book and was most impressed with the complete coverage of the subject of drugs today and would recommend that all practitioners, regardless of the area of activity, have this publication at hand.

IRVIN W. WILKENS, M.D.
Indianapolis

FIBER & BRAN BETTER HEALTH COOKBOOK

Cory SerVaas, M.D., Charlotte Turgeon, Fred Birmingham, Curtis Publishing Co., Indianapolis, 1977.

Cory SerVaas, M.D., Charlotte Turgeon and Fred Birmingham have come up with a winner. The authors have produced "the most enticing cookbook of fiber and bran recipes that has ever been assembled." This reviewer cannot disagree with their assertion. *Fiber & Bran Better Health Cookbook* is basically a cookbook. The recipes are practical and could be implemented by virtually any housewife. But this book is more than a mere cookbook: it represents a clarion call to the importance of fiber and bran in our diet. Hence, it comprises a detailed introduction (14 pages) that present, by Dr. Cory SerVaas, the rationale for the cookbook. Further, among the multitude of recipes useful in providing more fiber and bran in the diet are short, rational introductions. In a word, this book presents a program to promote rational health through nutrition. Its full color artwork contributes to this goal, as do its black-and-white drawings so strongly reminiscent of *Alice in Wonderland*. The book is enthusiastically recommended for doctors and patients interested in better health through better nutrition.

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TAX TIPS

LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

If a donor makes a gift (after 1976) and splits the gift with the donor's spouse, for gift tax purposes under §2513, and the donor dies within three days after making the gift, then, in general, the value of the gift (at the donor's death or at the alternative valuation date less the value of the donor's gift tax exclusion of up to \$3,000) is includable in the donor's gross estate for estate tax purpose under §2035. In addition, the donor's gross estate must include, under §2035, any gift taxes which the donor paid in respect of the gift. However, if the donor's spouse paid some gift tax in respect of the split gift, *out of the spouse's own funds*, then none of the spouse's gift tax payment is includable in the decedent's gross estate (because the *decedent's* funds were not used for that payment, and the *decedent's* gross estate was not reduced by that payment).

On the other hand, if the spouse predeceases the donor, then none of the value of the gift is includable in the spouse's gross estate (because the spouse did not, in fact, make the gift). However, if the spouse paid some of the gift tax, then the spouse's gift tax payment is includable in the spouse's gross estate (because, otherwise, the spouse could reduce the spouse's gross estate during the critical three-year period by making such payments).

If the donor did not pay the gift tax which may be due because of the gift, then the gift tax will, as under the pre-1977 law, be deductible as a claim against the donor's gross estate, for estate tax purposes, under §2053(a)(3). And, if the decedent's personal representative pays the applicable gift tax during the administration of the decedent's estate, then, under section 2035, the gift tax so paid will increase the decedent's gross estate.

However, consider the unique and ethic-raising case, in which the decedent's gross estate is not sufficient to require

the filing of an estate tax return unless the personal representative pays the gift tax which the personal representative has determined as being owed. That is, if such gift tax is so paid, then the decedent's estate is increased by the gift tax so paid and the estate tax return is clearly due. On the other hand, because §2035 only states that a decedent's gross estate is increased by the gift taxes "paid" by, for example, the decedent's personal representative, an argument could be made that no estate tax return is due, in the case described, unless such gift tax is paid. Despite this statutory defect, the Internal Revenue Service could easily draft Regulations which would require the filing of an estate tax return, in such a situation, even if the gift tax was paid.

Once an individual has survived the three-year period, then, as under pre-1977 law, §2035 does not require inclusion of either the gift or the gift taxes which are paid in respect of the gift.

Another question which has been raised concerns the relationships among §2035, §2040, and §2515. That is, as I will discuss in a future article, §2040 provides that a decedent's gross estate will not include one-half of a *qualified joint interest* in property. And, one type of a qualified joint interest is the interest which spouses have in real estate, the title to which is held by the spouses as tenants by the entirety or as joint tenants with rights of survivorship, and the donor spouse has elected under §2515 to have the gift (of the interest on the real estate to the other spouse) taxable for gift tax purposes. *Ostensibly*, if a donor makes the §2515 election for the purpose of excluding one-half of the real estate from the donor's gross estate, and then, the donor dies within three years, only one-half of the value of the real estate (at the decedent's death or at the alternative valuation date) is includable in the decedent's gross estate. *However*, in my opinion, §2040 (b) (1) is clear: that only one half of the value of the real estate is includable "by reason of (§2040)"; and, that §2040 does not exclude the operation of any other section. Thus, if §2035 is otherwise applicable, then the value of such real estate which is includable in the decedent's gross estate is the greater of the value determined under §2040 and §2035. That is, simply stated, §2035 triumphs over §2040.

Another question which has been raised about §2035 concerns the relationships between §2035 and the various credits which are allowable against the estate tax. If a donor makes a gift prior to 1977, and pays gift tax on the gift, and dies after 1976, then, as stated above, the pre-1977 law is applicable to the gift. And, if the gift is includable in the donor's gross estate under §2035, then (because of the double taxation),

the donor is, in general, entitled to a credit against the estate tax (under §2013) for the gift which the donor paid in respect of the gift. Further, §2012 (c) provides, in general, that if the donor-decedent's spouse paid gift tax in respect of the gift because the gift was split between the spouses for gift tax purposes (under §2513), then the decedent may even credit the gift taxes (so paid by the spouse) against the decedent's estate tax. This credit is continued, with certain computation modifications, for gifts which were made prior to 1977 by individuals who die after 1976. However, the credit, with all of its computation modifications, is disallowed for gift taxes which are paid on gifts which are made after 1976.

On the other hand, if a donor makes a gift after 1976, and splits the gift with the donor's spouse, and then, the donor dies and the gift is included in the donor's gross estate for estate tax purposes, under §2035, then §2001 provides (without the necessity of the former complex computations) that the decedent is entitled to a credit against the decedent's estate tax for the amount of any gift tax which is payable with respect to the gift, which gift is treated as being made by the spouse due to the §2513 election. These credits will be discussed, in more detail, in a later article.

Now, despite all of the mechanical problems which are inherent in the new §2035, the most significant problem is whether §2035 is constitutional. And, if the estate tax is high enough or if the estate's lawyer is bold enough, the estate's lawyer will challenge the constitutionality of §2035, using the authority of *Heiner v. Donnan*, 285 U.S. 312 (1932). Of course, the statutory provision which was involved in that case was not part of a "unified" gift and estate tax law, and thus, when any court weighs the constitutionality of the current §2035, there will be many considerations which were not presented in the *Heiner* case. In a nutshell, the Supreme Court (using the analysis which was presented in *Schlesinger v. Wisconsin*, 270 U.S. 230 (1926)) held that the conclusive statutory presumption (which existed in the Revenue Act of 1926 and which required lifetime gifts, which were made within two years of a decedent's death, to be included in a decedent's gross estate, and which presumption would not be rebutted by the decedent's personal representative, violated the due process clause of the Fifth Amendment of the U.S. Constitution. The opinion is filled with provocative statements which can be utilized by any lawyer who wishes to take on the challenge. For example: "Such a statute is more arbitrary and less defensible against attack than the one imposing arbitrarily retroactive taxes, which this court has decided to be in clear violation of the Fifth Amendment."

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Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

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Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

Warning

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions:

Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions;

nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

**FOR LONG-TERM CONTROL
OF HYPERTENSION*
SERUM K⁺ AND BUN SHOULD
BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)**

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Neosporin[®] Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

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Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin[®] Ointment (polymyxin B-bacitracin-neomycin).



Wellcome

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Research Triangle Park
North Carolina 27709

Neosporin[®] Ointment

Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin[®] brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

OLBY PROCLAIMS WOMAN SUFFRAGE

signs Certificate of Ratification
at His Home Without
Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony,
But Both Factions Are

WASHINGTON, Aug. 26, 1920—
by struggle Wom-



TRUMAN CLOSES UNITED NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great
Instrument of Peace,'
Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session the President announced the

Social Security Bill Is Signed Gives Pensions to Aged, Jobless

**Roosevelt Approves Message Intended to Benefit 30,000,000
Persons When States Adopt Cooperating Laws—Hails
the Measure 'Cornerstone' of His Economic Program**

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10,
1971—The Senate approved

WASHINGTON, Aug. 26.
The Social Security Bill, a broad program of unemployment insurance and old age and counted upon to benefit 20,000,000 persons, became law today when it was signed by President Roosevelt in the presence of those chiefly responsible for bringing it through Congress.

Mr. Roosevelt called it "the cornerstone" of his economic program which is being completed in the near future.

the Draft Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.



THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

The Auxiliary Reports to ISMA



Our guest columnist this month is Mary Johnson (Mrs. Thomas W.) of Indianapolis. Mary needs no introduction because of her many years of involvement with Auxiliary activities—from the lowest of jobs to service as president of the Marion County Auxiliary and president of the state Auxiliary in 1962-1963. She has served as historian for many years and requests help for two of our projects.

Mary K. Stanley

Mary K. (Mrs. John R.) Stanley
President, ISMA Auxiliary

History is that branch of knowledge concerned with past events, especially those involving human affairs. It is a narrative that recounts events with attention to their importance, their mutual relations, causes and effects. What field could be more proud of its history, more interested in the present, or concerned with its future than the field of medicine?

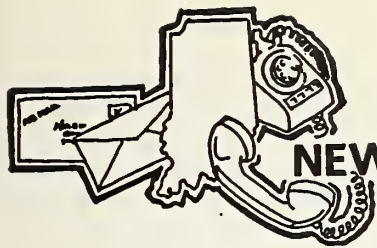
During the presidency of Mrs. Edsel Reed, we asked for and were able to obtain a history of many of the County Medical Societies. We also have a short history of each Medical Auxiliary. These have been compiled into a book, one copy of which was presented to our state Medical Museum, and one to the ISMA.

It is our hope to make this 100%, so if any of you doctors are in one of the groups who did not respond to our first inquiry, we would certainly appreciate a short history of your County Medical Society to be added to the book.

Another ongoing project of the Auxiliary has been the acquisition of a picture of each of our former state Auxiliary presidents. These we are hanging in the Auxiliary room at the ISMA. At this time we have 47 out of the 50 who have served. The three we do not have are: Mrs. W. R. Davidson of Evansville (1928-29), Mrs. W. S. Tomlin of Indianapolis (1930-31), and Mrs. I. N. Trent of Muncie (1933-34). If anyone has an idea where a picture of any of these women might be obtained, we would like very much to hear from you.

MRS. THOMAS W. JOHNSON
Historian





NEWS NOTES

Dr. Bonsett Named Associate Editor

The Board of Trustees has appointed **Dr. Charles A. Bonsett**, Indianapolis neurologist, to the staff of *The Journal* as an Associate Editor. Well known to readers of *The Journal* as the editor of the Medical Museum Notes page, Dr. Bonsett has also served as chairman of the Medical History Section of the Indiana Historical Society and editor of the *Indiana Medical History Quarterly*, all of which ties in with his supervision of the Medical Museum in the Old Pathology Building at 3000 W. Washington St., Indianapolis.

Dr. Alvin J. Haley, Fort Wayne, and **Dr. Wei-Ping Loh**, Gary, were both reappointed by the Board to three-year terms on the editorial Board of *The Journal*.

Dr. Lowell Thomas Named to Board

The Curriculum Review Board of the American Association of Medical Assistants has announced that **Dr. Lowell I. Thomas**, Indianapolis orthopedic surgeon, has been named to the Board to serve until the fall of 1979. He is immediate past chairman of the AAMA Physician-Advisory Board.

New Toll Free Poison Information Number

Recently the Indiana General Assembly established (Public Law 176—Acts of 1977) a toll free number for Indiana citizens to contact the Poison Control Center at Wishard Memorial Hospital, Indianapolis, when confronted with a poisoning emergency. The number was changed to **800-382-9097** as of Sept. 29. The Indianapolis area number, **633-0399**, remains unchanged.

Secretaries Honor Dr. Donald Roegner

Dr. Donald L. Roegner, Kokomo, was named Boss of the Year at the recent annual "Executive Night" of the Kokomo Chapter, National Secretaries Association. He is a psychiatrist at the Family Psychiatric Center in Kokomo.

Graessle Memorial Fund Established

The Dr. H. P. "Bud" Graessle Memorial Fund has been established through the Jackson County Schneck Memorial Hospital Foundation to honor the memory of the late physician. Dr. Graessle practiced in the Seymour area for 53 years, retiring in 1971.

Conference Scheduled, Abstracts Sought

The Second National Conference on Need Assessment in Health and Human Services will be held at the Bluegrass Convention Center, Louisville, March 27 to 31, 1978. Participation is open to, and abstracts are being solicited from, professional workers in psychiatry, psychology, education, sociology, social work, public health, administration, nursing, medicine and other related disciplines. Write to Roger A. Bell, Director, University of Louisville School of Medicine, P.O. Box 1055, Louisville 40201.

Dermatologists Hold Annual Meeting

Twenty-four cases were presented at the morning clinical meeting of the Section on Cutaneous Medicine, followed by a discussion conducted by Dr. Walter Epinette, professor of Dermatology at the Indiana University School of Medicine. The meeting was held at the Regenstrief Center on the I.U. Medical Center campus and was the Section's contribution to the Annual Meeting of the ISMA.

Dr. Robert Baehner of the Department of Pediatric Hematology-Oncology spoke at the afternoon session on "Recognizing the Immunosuppressed Child."

Officers elected for 1977-78 were: **Dr. Edward Probst**, Columbus, chairman; **Dr. William Cron**, Bloomington, vice-chairman, and **Dr. Patrick Logan**, Indianapolis, secretary-treasurer.

Library Dedicated to Dr. Salon

The work and memory of the late **Dr. Nathan L. Salon**, Fort Wayne, were honored recently, as part of the Governor's Conference on Aging, by dedication of the Nathan L. Salon Resource Center, a reference library on geriatrics and gerontology, at the offices of the Commission on Aging, 215 N. Senate Ave., Indianapolis.

Surgeons Inducted into Fellowship

A number of Hoosier surgeons were inducted into Fellowship in the American College of Surgeons at the group's recent Clinical Congress in Dallas. They are: **Drs. John L. Rubush**, **Ian Ross Gardner** and **Frank Walerko**, all of South Bend, **Drs. Jerome E. Melchior** and **Ralph W. Stewart**, Vincennes, **Dr. Kirby B. Tarry**, Columbus, and **Drs. Thomas E. Durham** and **Michael H. Thomas**, Elkhart.



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Dr. Harshman Named President-Elect



Dr. James A. Harshman, Kokomo pathologist, was named president-elect of the Indiana State Medical Association at the 128th Annual Meeting in Indianapolis in October. He will assume the presidency at the 1978 Annual Meeting. Dr. Harshman received his M.D. degree from Indiana University in 1955 and served his internship and residency at the University hospitals. He was a resident instructor in pathology from 1956 to 1960. From July 1960 to July 1962 he was on active duty at the U.S.

Naval Hospital, Great Lakes, Ill., and continued as a member of the Naval Reserve until 1964. Dr. Harshman is a diplomate of the American Board of Pathology, the American Board of Clinical Pathology and the American Board of Nuclear Medicine. His activities with the medical organizations with which he is affiliated are numerous, both at the local and state level. He is presently serving as a delegate to the American Medical Association, having served as alternate delegate since 1968. He has been a member of the Indiana State Medical Association since 1957 and served on numerous committees and commissions. In addition, he has been a trustee since 1972 and served as chairman of the Board of Trustees for the past year as well as a member of the Executive Committee.

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At the address of distinction in Indianapolis:

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Limited availabilities from \$270 to \$1,250. Inquiries invited.

In January 1977 Dr. Harshman was appointed to the State Health Coordinating Council. Other professional positions he has held or now holds are: faculty member of the Division of Allied Health Sciences at I.U.-Kokomo, director of nuclear medicine at St. Joseph Memorial Hospital since 1965, chief of medicine at Howard Community Hospital in 1968, president of the medical staff of St. Joseph in 1974 and secretary of the Howard County Medical Society in 1963.

Among community activities have been stints as director of the Kokomo Area Chamber of Commerce, director of the Howard County Red Cross and of the Cancer Society and member of the City Planning Commission and the Mayor's Task Force on Drug Abuse.

Dr. and Mrs. Harshman and their five children reside in Kokomo.

Schedule for Upcoming NCME Programs

The Network for Continuing Medical Education announces the following schedule of programs:

Dec. 12-25 "THE INITIAL MANAGEMENT OF MULTIPLE TRAUMA," with Clement A. Hiebert, M.D., thoracic surgeon, Moine Medical Center, Portland, Me.

"ACCIDENTAL HYPOTHERMIA: A CONSIDERATION AND A PRIORITY," with Cameron C. Bangs, M.D., internist, Willomette Falls Community Hospital, Oregon City, Ore., and clinical instructor of medicine, University of Oregon Health Science Center, Portland.

"RECENT ADVANCES IN THE MANAGEMENT OF PEPTIC ULCER DISEASE," with Henry J. Binder, M.D., associate professor of medicine, Yale University School of Medicine, New Haven.

Dec. 26-Jan. 8, 1978 "REDUCING THE OPERATIVE RISK OF ELECTIVE SURGERY: INFLUENCE OF AGE AND CARDIOVASCULAR DISEASE," with Hiram C. Polk, Jr., M.D., professor and chairman of the Department of Surgery; John S. Sprott, Jr., M.D., professor of surgery and deputy director of the Cancer Center, and Donald E. Fry, M.D., instructor in surgery, University of Louisville School of Medicine, Louisville.

"REDUCING THE OPERATIVE RISK OF ELECTIVE SURGERY: INFLUENCE OF DIABETES, PULMONARY, RENAL AND LIVER DISEASES," with Hiram C. Polk, Jr., M.D., and Carl O. Knutson, M.D., associate professor of surgery and director of the Surgical Endoscopy Center, University of Louisville School of Medicine, Louisville.

"REDUCING THE OPERATIVE RISK OF ELECTIVE SURGERY: INFLUENCE OF NUTRITIONAL STATE AND USE OF MEDICATIONS," with Hiram C. Polk, Jr., M.D., John S. Sprott, Jr., M.D., and Neal Garrison, M.D., instructor in surgery, University of Louisville School of Medicine, Louisville.

Jan. 9-Jan. 22 "FROSTBITE: DECREASE TISSUE LOSS," with Cameron C. Bangs, M.D.

"VULVOVAGINAL CANDIDA, ALIAS MONILIA," with Leonord J. Cibley, M.D., F.A.C.O.G., assistant clinical professor, Department of Obstetrics and Gynecology, Boston University School of Medicine, and clinical instructor, Harvard Medical School, Boston.

"THE OVERGROWN INFANT: AN AMERICAN PROBLEM," with Myron Winick, M.D., director of the Institute for Human Nutrition, the R. R. Williams Professor of Nutrition and Professor of Pediatrics, Columbia University College of Physicians and Surgeons, New York City.

PMA Awards Biomedical Science Grants

The Pharmaceutical Manufacturers Association Foundation awarded more than \$450,000 in grants last year to students and faculty pursuing careers in biomedical sciences. Over \$7 million has been awarded to 400 individuals since the Foundation's inception in 1965.

The Foundation supports six programs:

1. Faculty Development Awards in Clinical Pharmacology.
2. Fellowships for Careers in Clinical Pharmacology.
3. Medical Student Research Fellowships in Pharmacology-Clinical Pharmacology.
4. Faculty Development Awards in Pharmacology.
5. Fellowship Awards in Pharmacology-Morphology.
6. Research Starter Grants.

Achievements of recipients of PMAF funding include four Faculty Awardees who have received NIH Research Career Development Awards; four Faculty Awardees who have received Burroughs Wellcome Fund Awards in Clinical Pharmacology and 34 recipients in the Starter Grant program who have since obtained \$1.6 million in additional grants.

Complete Fire Safety Program Available

A new instructional program of the slide-tape format is available from the National Fire Protection Association on the subject "Fire: It Could Happen to You." It emphasizes fire prevention and fire safety. Suitable to all ages. It contains 80 slides and a standard cassette tape and a discussion manual. An alternative format consists of a 35 mm filmstrip and cassette and manual. The first format costs \$29.50, the latter \$29.00. Write to NFPA at 470 Atlantic Ave., Boston 02210.

Seminars Announced, Stipends Offered

Humanities Seminars for Medical Practitioners, which have been conducted in years past by the National Endowment for the Humanities, will be continued in 1978. From 12 to 15 persons will attend each seminar tuition-free, receiving a stipend of up to \$1,200 to cover expenses, plus reimbursement for travel. Physicians, nurses, public health officials, hospital administrators and other health professionals may apply. Application deadline is tentatively set for April 17, 1978. Write to Professions Program, Division of Fellowships, National Endowment for the Humanities, Washington, D.C. 20506.

Pathlabs Buys Diamond Shamrock Labs

Diamond Shamrock Corporation has agreed in principle to sell all of its Indiana Regional Clinical Laboratories to Pathlabs, Inc. The property consists of a central laboratory in Indianapolis and 10 satellite collection stations throughout the state. Laboratory services will continue under local management.

Dr. Altemeier Chosen President-Elect

Dr. William A. Altemeier, chairman of the Department of Surgery at the University of Cincinnati College of Medicine, was recently elected president-elect of the American College of Surgeons. Dr. Altemeier is well known in Indiana and is world famous for his work on surgical infection, on shock and trauma and on the pharmacology of antibiotics.

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FUTURE MEETINGS, SEMINARS, COURSES

Virgin Islands Conference in January

The Third Annual Midwinter Virgin Islands Clinical Conference will be held at Bluebeard's Castle Hotel on St. Thomas, U.S. Virgin Islands, Jan. 26 to 28, 1978. The program is acceptable for 14 credit hours in Category 1. Lectures and seminars will include the fields of general practice, internal medicine, general surgery, Ob-Gyn and pediatrics, in association with the Faculty of The John Hopkins University School of Medicine. Write to Peter A. Curreri, M.D., Box 39, Red Hook, St. Thomas. V.I. 00801.

Antibiotic Therapy Symposium II

"Antibiotic Therapy Symposium II" will be held at the Center for Continuing Education on the campus of the University of Notre Dame on Feb. 22, 1978. Registration is open to all physicians in the midwest. The faculty is composed of nationally recognized authorities in the field. The proceedings will be taped and published. The registration fee of \$25 covers a luncheon, a copy of the Proceedings and refreshments at mid-morning and mid-afternoon breaks. For details write Dr. Robert I. Devetski, Department of Microbiology, University of Notre Dame, Notre Dame, IN 46556.

Postgraduate Courses in Michigan

The University of Michigan announces the following postgraduate courses, all of which will be held at the Towsley Center in Ann Arbor:

Date	Title	Target Audience
Mar. 1978		
3	Care of the Burned Patient	Nurses, Other Health Professionals
8-10	Hematology Review	Pathologists, Medical Technologists
16-17	Surgery Conference	General Surgeons
22-23	Advances in Pediatrics	Pediatricians
30-31	Neurological Problems in Family Practice	Family Physicians

Complete information is available from the Department of Postgraduate Medicine, Towsley Center for Continuing Medical Education, Ann Arbor 48109.

Polytomography of Temporal Bone Symposium Planned for Apr. 15-16

The 18th two-day Symposium on Polytomography of the Temporal Bone will be given under the auspices of The Wright Institute of Otology at Community Hospital, Indianapolis, on Apr. 15 and 16, 1978. As an organization accredited for continuing medical education, the Wright Institute of Otology, Inc., certifies that this continuing medical education activity meets the criteria for 12 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Subjects covered are: "Basic Anatomy of the Temporal Bone" and "Technique of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological

conditions revealed by polytomography, such as cholesteatoma, ossicular chain problems, otosclerosis, fractures, foreign bodies, tumors, and congenital anomalies are shown on original tomograms and the clinical applications discussed.

Fee for the course is \$250.

Inquiries should be directed to: The Wright Institute of Otology, Inc., Community Hospital of Indianapolis, 1500 N. Ritter Ave., Indianapolis 46219; phone: 317-353-5679.

11th Annual PG Course at Milwaukee

Gynecologic Pathology, Cytogenetics and Endocrinology is the subject of the 11th Annual Postgraduate Course of the Medical College of Wisconsin to be held March 30 to April 5, 1978, at the Pfister Hotel in Milwaukee. The fee is \$400, which will include a set of 60 35 mm slides. Write to Dr. Richard Mattingly, 8700 W. Wisconsin Ave., Milwaukee 53226.

Courses at Lexington Announced

The Continuing Education Division of the College of Medicine, the University of Kentucky, Lexington, has announced three courses, all of which will be held at the Hyatt Regency, Lexington, as follows:

Diabetes Control: Why and How, Apr. 14-15;

Medical and Behavioral Problems in Older Persons, May 4-5;

Surgical Diseases in Children: Radiologic Evaluation and Operative Correlation, May 17-19.

Further information may be obtained by writing Frank R. Lemon, M.D., Continuing Education Division, University of Kentucky College of Medicine, Lexington 40506.

Neonatal Pediatric Dilemmas Subject

"Major Dilemmas in Neonatal Pediatrics" will be the subject of the annual Newborn Symposium at the Methodist Hospital, Indianapolis, on April 18 and 19, 1978. Perinatal asphyxia and its effects, the question of solid feedings in early infancy and limits of nursing responsibility will be among the topics discussed. For full details write Richard S. Baum, M.D., 1604 N. Capitol Ave., Indianapolis 46202.

Child Care Conference Set for May 18-19

The Thirteenth Annual Indiana Multidisciplinary Child Care Conference will be held at the Marriott Inn, Indianapolis, on May 17 and 18, 1978.

The seminar leaders and topics are Drs. Jack Paradise and Charles Bluestone—Pediatric ENT; Drs. Jerry Bergstein and Al Michael—Pediatric Nephrology; Drs. Virgil Hansen and Bram Bernstein—Pediatric Rheumatology; Drs. Samuel Wentworth, Donnell Etwiler and Jamie Davidson—Diabetes in Children; Dr. Murray Feingold—Visual Diagnosis; Dr. Jerome Klein—Pediatric Infectious Disease; Dr. Norman Foster—Medical Ethics; banquet speaker—Dr. C. Henry Kempe: "Child Abuse—The Pediatrician's Role in Child Advocacy and Preventive Pediatrics."

For further information contact Dr. Morris Green, 1100 West Michigan St., Indianapolis 46202.

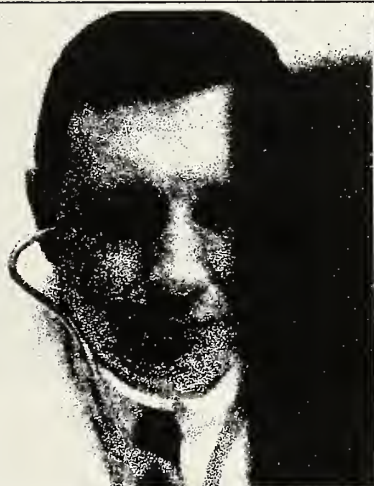
Indiana University School of Medicine

announces

Continuing Medical Education Opportunities—1978

Title	Date	AMA Category 1 Credit
Office Urology	Jan. 25	6
Thyroid Disease (Richmond)	Feb. 2	6
7th Annual Fred Priebe Symposium on Arthritis	Feb. 15	6
Current Concepts in Internal Medicine	Mar. 1-2	14
Aspiration Syndromes	Mar. 14-15	10
Leukemias and Lymphomas (Richmond)	Mar. 23	6
Brain Disorders	Mar. 29	6
Clinical Electrocardiography	May 3-4	12
Pediatric Radiology	May 10-12	18
What's New in Obstetrics and Gynecology	May 10-11	12
Family Review I	June 13-15	26
63rd Annual Head and Neck Anatomy and Clinical Otolaryngology	July 10-21	116
Family Review II	July 18-20	26
Care of the Emergency Room Patient	Aug. 3-4	12

All programs, except those marked Richmond, are to be held in Indianapolis. For further information write Mr. John Roscoe, Division of Postgraduate and Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46202; phone 317-264-8353.



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Deaths

Howard Aldrich, M.D.

Dr. Howard Aldrich, 75, Indianapolis, died Sept. 22 in Community Hospital.

He maintained an office on Indianapolis' east side from 1929 until he retired in January. He was a 1928 graduate of the Indiana University School of Medicine.

He attained Senior Membership in the Indiana State Medical Association in 1972 and was a member of the Marion County Medical Society and the American Medical Association.

Harold P. Graessle, M.D.

Dr. Harold Peter Graessle, 83, a retired Seymour physician and surgeon, died Oct. 7 in Jackson County Schneck Hospital. He practiced at Seymour for 53 years, retiring in 1971.

A 1918 graduate of the Indiana University School of Medicine, Dr. Graessle interned at St. Vincent Hospital, Indianapolis. He was a World War I veteran.

Dr. Graessle was active in organized medicine on the local, state and national level, serving as a delegate to the American Medical Association from 1936 to 1951, as a Councilor of the Indiana State Medical Association from 1928 to 1935 and on the Committee on Public Relations in 1939 and 1940. He also served in various offices of the Jackson County Medical Society. He became a Senior Member of the ISMA in 1964 and a member of the 50-Year Club in 1968.

William L. Green, M.D.

Dr. William Lennis Green, Shelbyville surgeon, died Sept. 17 at Major Hospital. He was 70.

Dr. Green was serving his second term as county coroner, was past chief of staff and currently chief of the surgical staff of Major Hospital.

A graduate of the Indiana University School of Medicine in 1933, Dr. Green interned at Indianapolis General Hospital, after which he served a seven-year preceptorship with Drs. Thomas Noble, Sr. and Jr. He served on hospital staffs at Indianapolis and Kalamazoo, Mich., from which city he came to Shelbyville in 1962. During World War II he served with the Marine Corps in the South Pacific area.

Dr. Green was a Fellow of the International College of Surgeons and served as president of the Shelby County Medical Society. He was also a member of the American Medical As-

sociation and was a Senior Member of the Indiana State Medical Association.

Richard B. Hovda, M.D.

Dr. Richard Berger Hovda, Evansville radiologist, died Sept. 21 at Welborn Hospital. He was 52.

Dr. Hovda became chief of radiology at St. Mary's Hospital in 1957, when he came to Evansville from Evanston, Ill., where he was chief of radiology at Northwestern University Medical School clinics. For the past seven or eight years he had been in private practice.

He did his internship and residency at Evanston Hospital. During World War II he was a pilot with the Navy Air Corps. He was one of the trustees who helped set up the Red Cross regional blood program in Evansville.

Dr. Hovda was a member of the American College of Radiology, the Vanderburgh County Medical Society and the American Medical Association. He served on the Indiana State Medical Association's Commission on Special Activities in 1973 and on the Convention Arrangements Committee in 1967 and for a number of years before that.

John F. Kerrigan, M.D.

Dr. John Francis Kerrigan, Michigan City surgeon, died Oct. 5 in St. Anthony Hospital. He was 55.

He received his M.D. degree from Northwestern University in 1947 and interned at Cook County Hospital before joining the Army in 1948, where he served as assistant chief of surgery at West Point Hospital, following which he returned to Cook County Hospital, where he was night warden for two years.

Dr. Kerrigan opened his practice in Michigan City in 1952 and was on the staff of both St. Anthony and Memorial Hospitals, serving in all posts on the former's medical staff, including a term as president. He was instrumental in setting up the Council for Health Education in 1960, a community service organization that promoted community health education. The CHE did community-wide tests for uterine cancer, diabetes and heart disease. He also helped establish the Northern Indiana Health Systems Agency's predecessor.

A Fellow of the American College of surgeons since 1959, Dr. Kerrigan served as president and secretary of the LaPorte County Medical Society and was a member of the American Medical Association.



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The 1977 Convention Story



OUTGOING PRESIDENT John W. Beeler receives a handsome plaque commemorating his year as head of the Indiana State Medical Association from his successor, Dr. Eli Goodman, Charlestown (above).

THE HOUSE OF DELEGATES was hard at work when the photographer happened along to photograph them. (Below)





MEMBERS of the Indiana Society, American Association of Medical Assistants, Inc., held a working session in connection with the ISMA Annual Meeting.



THE IMPAC board of directors met on Monday afternoon before the banquet at which Congressman Guy VanderJagt of Michigan was the speaker.



MEMBERS OF THE EDITORIAL BOARD were photographed with the plaque awarded The Journal last year as the best of the larger state medical journals. Dr. Frank B. Ramsey, editor, holds the plaque which was awarded by the Sandoz Pharmaceutical Co. Left to right are: Dr. Elton Heaton, Madison; Dr. Dan Snively, Evansville; Dr. Irvin Wilkens, Indianapolis, Dr. Ramsey, Dean Steven C. Beering, Indianapolis, Dr. A. W. Cavins, Terre Haute, and Dr. Sam Mercer, Fort Wayne.



A HEARTY "Thank you" for a presentation at the meeting of the Section on Public Health. (Above left)



VISITORS study one of the Scientific Exhibits. (Above right)

OUTSIDE the House of Delegates' meeting where Miss Elsie Reid was handling registration of delegates. (Right)



MEMBERS of the Section on Directors of Medical Education gave rapt attention to one of their speakers. (Below)





RADIOLOGISTS held their meeting on Sunday.



ANOTHER Sunday meeting was that of the Association of American Physicians and Surgeons. (Left)

THE BASIC CPR course was presented at the meeting of the Section on Emergency Medicine.





THE REFERENCE COMMITTEE on Rules and Order of Business met on Sunday night before the Reference Committees met.

AT ONE OF THE Reference Committee Meetings.



THE SECTION on Internal Medicine met with the American College of Physicians (Indiana) and the Indiana Society of Internal Medicine. (Below)





DR. WILLIAM M. SHOLTY, Lafayette anesthesiologist, received the A. H. Robins Company Community Service Award, which was presented by Dr. Beeler.

DR. RICHARD L. SCHREINER (left) was winner of first award for his scientific exhibit; the exhibit of Dr. Patrick A. Dolan was second—an associate accepted the award for Dr. Dolan—and that of Dr. Anastacio Ng was third. (Center above)

THE 1977 NEWSPAPER award went to Gene Policinski, Indianapolis, while Denise LeClair, former reporter with WFIE-TV, Evansville, received the plaque for the best television series.

DR. CHARLES A. BONSETT (left) greets a group of visitors to the Medical History Museum.

DR. JOHN BEELER (left) congratulates the new members of the 50-Year Club. (Below)





IN ADDITION TO officers of the Association, honored guests seated at the head table at the President's Dinner, including Dr. John H. Budd, president of the American Medical Association, and Governor and Mrs. Otis R. Bowen.

DR. JOHN H. BUDD, AMA president, addresses the House of Delegates as Dr. Lloyd L. Hill, Peru, speaker of the House and Dr. Lawrence Allen, Anderson, look on.



SWEARING IN of the new officers and trustees took place at the last session of the House of Delegates.



Convention Election Results

Dr. James A. Harshman Named President-Elect

Dr. James A. Harshman, Kokomo, was elected president-elect of the Indiana State Medical Association at the closing session of the House of Delegates at the Annual Meeting in October. He succeeds Dr. Eli Goodman, Charlestown, who was installed as president on Oct. 26.

(An account of the career and service to organized medicine of Dr. Harshman appears in this month's "News Notes.")

Dr. Arvine Popplewell, Indianapolis, and Dr. Joseph F. Ferrara, Franklin, were reelected treasurer and assistant treasurer, respectively.

Dr. Martin J. O'Neill, Valparaiso, was elected chairman of the Board of Trustees, while Dr. John W. Beeler, outgoing president, was elected chairman of the Executive Committee. Two who have been serving as members-at-large were reelected to the Executive Committee. They are Dr. Richard G. Ingram, Montpelier, and Dr. Joe Dukes, Dugger.

Drs. Lloyd L. Hill, Peru, and Lawrence E. Allen, Anderson, were reelected to serve as speaker and vice-speaker of the House of Delegates.

New trustees chosen for three-year terms by their districts are Dr. John Bizal, Evansville, First District;

Dr. Donald C. McCallum, Indianapolis, Seventh District, and Dr. Donald S. Chamberlain, South Bend, Thirteenth District. Dr. Herbert C. Khalouf, Marion, will also be serving as trustee for the first time. Elected alternate trustee for the Eleventh District at the district's 1977 annual meeting, Dr. Khalouf moved up to the position of trustee when Dr. James A. Harshman resigned that office upon his election as president-elect. Dr. Frederick C. Poehler, LaFontaine, replaces him as alternate trustee.

Dr. Howard C. Jackson, Madison, Fourth District, and Dr. Martin J. O'Neill, Valparaiso, Tenth District, were reelected to three-year terms.

Three alternate trustees were reelected to three-year terms. They are Drs. Richard G. Huber, Bedford, Max N. Hoffman, Covington, and Franklin A. Bryan, Fort Wayne, representing the Third, Ninth and Twelfth Districts, respectively.

Incumbent delegates and alternate delegates to the American Medical Association were reelected; delegates are Drs. Peter R. Petrich, Attica, and Patrick J. V. Corcoran, Evansville, while Drs. Thomas C. Tyrrell, Hammond, and Marvin E. Priddy, Fort Wayne, are the alternate delegates.

About Our Cover

Its first name is "children," but it's over 50 years old and far from small. In fact, in its bold new \$6.8 million home, The Children's Museum, Indianapolis, is the largest such museum in the world.

Several Indiana doctors share in the success of this outstanding museum which has attracted nearly one million visitors since it opened in October 1976. Cardiologist Dr. John N. Pittman and surgeon Dr. George H. Rawls have served on the museum's board of trustees during the years when the new museum facility was developed and opened.

Restoration of one of the museum's most popular exhibits, the bright red, 1918 fire engine on our cover was accomplished by Indianapolis orthopedic surgeon Dr. John G. Suelzer and his children, John, Andrew, Tom and Jennifer.

The Children's Museum is situated on five acres in Indianapolis' central city at the corner of 30th and Meridian Streets. Its 215,000 sq. ft. brick and aggregate concrete building is designed in four modules. Connecting the gallery wings is a skylit open core with carpeted, zig-zagging ramps rising 60 feet to five exhibit levels.

Inside the spacious galleries are the treasures on which youthful imaginations thrive—fire engines and trains, dinosaurs and mummies, a cave, a cabin and a carousel, to name a few.

A portion of the museum's outstanding collection of toy trains speeds through mountain tunnels, across bridges and past the cities, industrial park, old town village and circus scene on a 1,000 sq. ft. operating layout of Lionel O-gauge trains.

Thanks to the Lilly Foundation, which pledged \$3.5 million to the project, contingent upon the commitment of an equal amount from other sources, construction of the museum's new home and the expansion of existing features as well as the addition of many new ones became a reality and the museum opened its doors on Oct. 2, 1976, enchanting adults as well as children.

The museum is open from 10 a.m. to 5 p.m., Tuesday through Saturday and from 1 p.m. to 5 p.m. on Sunday. It is closed on Monday. There is no admission charge. ◀

Minutes of the House of Delegates

1977

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Proceedings of the House of Delegates

Indiana State Medical Association
Oct. 23, 26, 1977
Indianapolis

Call to Order and Miscellaneous Business

The House of Delegates convened at the 128th Annual Convention at 3 p.m. EST on Sunday, Oct. 23, in the Hyatt Regency Indianapolis, with Dr. Lloyd L. Hill, speaker of the House, presiding, assisted by Dr. Lawrence E. Allen, vice-speaker. The Wednesday session, Oct. 26, convened at 9 a.m. EST in the Hyatt Regency Indianapolis. Dr. Lester Hoyt, Indianapolis, served as parliamentarian for both sessions. Invocation was given by Dr. Hugh Thatcher, Indianapolis. The Paul Coble Legion Post presented the colors. Dr. Robert M. Brown, Marion, chairman of the Credentials Committee, reported a quorum for both sessions.

In Memoriam

Following is a list of members of the Indiana State Medical Association who have died since the 1976 annual session: HAROLD C. ADKINS, Indianapolis; HOWARD ALDRICH, Indianapolis; CHARLES L. ARMINGTON, Anderson; THOMAS D. ARMSTRONG, Michigan City

SIDNEY S. ARONSON, Indianapolis; PAUL A. BATTIES, Indianapolis; JOHN P. BAXTER, Indianapolis; JESSE C. BENZ, Marengo; MAURICE M. BEST, New Albany; ROBERT W. BOSWELL, Evansville; ROBERT L. BROWN, Evansville; SAMUEL S. CAPLIN, Indianapolis; RICHARD L. CARTER, Valparaiso; DONALD D. CHEESMAN, Danville; IVAN A. CLARK, Paoli; DAVID R. CLUTTER, Indianapolis; CHESTER C. CONWAY, Indianapolis; ROBERT W. DONNELLY, Indianapolis; WILLIAM DUTCHMAN, Muncie; FRANCIS M. FARGHER, Michigan City; H. P. GRAESSLE, Seymour; WILLIAM L. GREEN, Shelbyville; THOMAS C. HALLER, Crawfordsville; WILLIAM L. HARLAN, Evansville; MARTIN C. HECK, Santa Claus; JOHN W. HENDRICKS, Indianapolis; MURYWN L. HICKS, Indianapolis; RICHARD B. HOVDA, Evansville; ROBERT F. JEANS, Richmond; ORAN E. KAY, Spencer

WILLIAM A. KEMP, Bourbon; RICHARD M. LAYCOCK, Fort Wayne; EDWIN L. LIBBERT, Columbus; NORMAN S. LOOMIS, Indianapolis; SAMUEL MARTIN, Corydon; J. WINFORD MATHER, East Gary; W. BURLEIGH MATTHEW, Indianapolis; CHARLES O. McCORMICK, JR., Indianapolis; DAN T. MILLER, Fowler; GEORGE E. MOSES, Worthington; BYRON NIXON, Farmland; MARINA NONO-ROSALES, Munster; CAREY B. PARKER, Fort Wayne; HARRY C. PARKER, Hobart; CECIL L. RUDESILL, Indianapolis; ROBERT E. SABINA, Munster; HERBERT C. SCHLOSSER, Elkhart; LOREN F. SCHMIDT, Indianapolis; CARL SCHNEIDER, Indianapolis; ROBERT O. SCOTT, Indianapolis; PAUL E. STRUEH, Evansville

Approval of Minutes

The proceedings of the 127th annual meeting of the House of Delegates held at the Indianapolis Hilton and published in the December 1976 Journal of the Indiana State Medical Association were approved.

Introduction of Guests

Introduced to the House were Dr. Robert D. Hess, President-elect, West Virginia State Medical Association; Dr. Leslie L. Swanson, President, Iowa Medical Society; and Dr. John H. Budd, President of the American Medical Association, who cited and commended the Indiana Delegation and those from Indiana on AMA councils and committees for their extensive efforts on behalf of organized medicine.

Congratulations Extended

Accolades were extended to Guy Ingwell, M.D., for his 25 years of service as delegate from Starke County.

Mrs. Chester Young, president of the AMA Auxiliary, sent a congratulatory telegram to Mrs. John Stanley, president ISMA Auxiliary, for the celebration of the Auxiliary's 50th anniversary. Dr.

John Beeler also congratulated the Auxiliary and presented Mrs. Stanley with a large bouquet of yellow roses.

Election of AMA Delegates and Alternate Delegates

The following were elected to two-year terms as delegates and alternate delegates to the American Medical Association, their terms to expire December 31, 1979. Delegate, Patrick J. V. Corcoran, Evansville; Alternate, Thomas C. Tyrrell, Hammond; Delegate, Peter R. Petrich, Attica; Alternate, Marvin E. Priddy, Fort Wayne.

Election of Officers

Dr. Eli Goodman, Charlestown, assumed the office of president and Dr. James Harshman, Kokomo, was elected president-elect. Dr. Arvine G. Popplewell, Indianapolis, was reelected treasurer. Dr. Joseph F. Ferrara, Franklin, was reelected assistant treasurer. Dr. Martin J. O'Neill, Valparaiso, was elected chairman of the Board of Trustees. Dr. John Beeler, Indianapolis, was elected chairman of the Executive Committee. The two at large members elected to the Executive Committee were Doctors Richard Ingram, Montpelier, and Joe Dukes, Dugger. Dr. Lloyd L. Hill, Peru, was reelected speaker of the House of Delegates and Dr. Lawrence E. Allen, Anderson, was reelected vice speaker of the House of Delegates.

Election of Trustees

Elected/reelected Trustees:

John A. Bizal, Evansville (First District); Howard C. Jackson, Madison (Fourth District); Donald C. McCallum, Indianapolis (Seventh District); Martin J. O'Neill, Valparaiso (Tenth District); Herbert C. Khalouf, Marion (Eleventh District); Donald S. Chamberlain, Mishawaka (Thirteenth District)

Elected/reelected Alternates:

Edgar R. Cantwell, Vincennes (Second District); Richard G. Huber, Bedford (Third District); I. E. Michael, Indianapolis (Seventh District); Gerald Kurlander, Indianapolis (Seventh District); Max N. Hoffman, Covington (Ninth District); Frederic Poehler, La Fontaine (Eleventh District); Franklin A. Bryan, Fort Wayne (Twelfth District); John W. Luce, Michigan City (Thirteenth District)

Scientific Exhibits Awards

First Award—Neonatal Radial Artery Puncture

Richard L. Schreiner, M.D., Department of Pediatrics, I.U. School of Medicine

Second Award—Gallium and Lymphography: A Comparison

Patrick A. Dolan, M.D., Director, Department of Radiology, Methodist Hospital, Indianapolis.

Third Award—Abdominal Computed Tomography

Anastacio, Ng, M.D., Department of Radiology, Methodist Hospital, Indianapolis.

Reference Committees of The House of Delegates

REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

L. Ray Stewart, Evansville (Vanderburgh)

Hugh K. Thatcher, Jr., Indianapolis (Marion)

Richard A. Brickley, Indianapolis (Marion)

Fred W. Dahling, New Haven (Allen)

I. E. Michael, Indianapolis (Marion)

REFERENCE COMMITTEE NO. 1

L. Ray Stewart, Evansville (Vanderburgh), Chairman

David E. Ross, Gary (Lake)

C. Stanley Manship, Hardinsburg (Washington)

Michael O. Mellinger, LaGrange (LaGrange)

James R. Daggy, Richmond (Wayne-Union)

REFERENCE COMMITTEE NO. 2

Hugh K. Thatcher, Jr., Indianapolis (Marion), Chairman

William F. Kerrigan, Connersville (Fayette-Franklin)

Robert Oehler, Brazil (Clay)

Eugene L. Hendershot, Evansville (Vanderburgh)

Barbara B. Backer, LaPorte (LaPorte)

REFERENCE COMMITTEE NO. 3

Richard A. Brickley, Indianapolis (Marion), Chairman

Donald M. Pell, Muncie (Delaware-Blackford)

Lee F. Dupler, Frankfort (Clinton)

Brockton L. Weisenberger, Columbus (Bartholomew-Brown)

Wilbur D. McFadden, North Manchester (Wabash)

Gary Lemmon, Indianapolis (Student Member)

REFERENCE COMMITTEE NO. 4

Fred W. Dahling, New Haven (Allen), Chairman

John Forchetti, Chesterton (Porter)

Ted S. Doles, Middletown (Madison)

Roger F. Robison, Bloomington (Owen-Monroe)

Paul Humphrey, Terre Haute (Vigo)

Fred Henney, Indianapolis (Student Member)

REFERENCE COMMITTEE NO. 5

I. E. Michael, Indianapolis (Marion), Chairman

George H. Rudwell, Jeffersonville (Clark)

Paul J. Wenzler, Bloomington (Owen-Monroe)

Robert M. Seibel, Nashville (Bartholomew-Brown)

Joseph D. Richardson, Rochester (Fulton)

Bill Miller, Indianapolis (Student Member)

CREDENTIALS COMMITTEE

Robert M. Brown, Marion (Grant), Chairman

Thomas C. Tyrrell, Hammond (Lake)

Loren H. Martin, Indianapolis (Marion)

Everett E. Bickers, Floyds Knobs (Floyd)

TELLERS

Jack W. Higgins, Kokomo (Howard)

R. Wyatt Weaver, Angola (Steuben)

C. David Ryan, Columbus (Bartholomew-Brown)

Address of the President John W. Beeler, M.D.

ACTION: Referred to the Board for consideration and implementation: (1) Change the ad hoc to a permanent Committee on Immunization; (2) Continue the ad hoc Committee on CAT Scanners; (3) Appoint an ad hoc Committee on Blue Shield charged specifically to consider the advisability of whether or not there should continue to be Indiana State Medical Association nominated representatives to the Board of Blue Shield.

Remainder of the report filed.

I would like to give several brief additions to my written report which was printed in the September issue of *The Journal*.

NEGOTIATIONS If ever this body needed proof that medical services are being manipulated by labor and management as a subject for negotiating for

benefits, please note the current program of medical eye services which was recently enacted for auto workers. Time doesn't permit a full discussion of this type of participating, non-participating program, which destroys the free choice of physician concept we have always supported. Time *does* allow me to say: This is why I believe the ISMA must immediately start to publicize the fact that physicians in Indiana expect—no, demand—to be consulted and to have input into any negotiation where our medical services are contracted. Any contract—national or state—which, for the purpose of cost control, jeopardizes the physician-patient relationship, affects quality of medical care and is divisive to medicine. Such contracts should be scrutinized, studied and negotiated!

MALPRACTICE. Next, a bit of good news relative to our current malpractice insurance situation. You have probably read Dr. Wilhelmus' article in the October issue of *The Journal* which explains well the continuing improved picture. This week I served on a panel with Insurance Commissioner Pete Hudson who stated he now has 111 claims which have requested a Panel Review. Twelve panels have been named, with only two panels terminated, one in favor of the plaintiff and one in favor of the defense. Of the 162 claims closed since 1975 (none of these having panels), 76% resulted in *no* payment for the claimant, a figure 10% above the national average. Although not out of the woods, we have come a long way and have every right to be proud of our progress.

GRIEVANCE COMMITTEE The Grievance Committee of the ISMA has formulated an orderly, concise and fair system to handle complaints and letters of grievance which are received by the society or its officers. There is an explicit time for reply and release of information, and there will always be a final determination. Since almost each complaint could become a cause for a medical malpractice suit on the part of one of our members, I feel that the concern I expressed to you last year has been resolved. The role of the county medical society is of major importance and its continued cooperation is absolutely necessary for the satisfactory functioning of the Grievance Committee.

PUBLIC RELATIONS Frequent news media interviews on anti-physician themes were constantly held and we submitted many press releases this year, i.e. the matter of immunizations. Testimony before State and Federal boards and panels on NHI probably changed for the better some objectionable situations, i.e., the matter of subscriptions for Medicaid patients. Strong defense of medicine and explanation of our acts and problems were voiced to everyone, particularly the

news media. When Eli Goodman turns loose the Charlestown newspaper called "The Leader" we will finally have an editor who will listen to medicine and, hopefully, improve further our public image.

I am reminded, in this vein, of a story of a relative of mine, Dr. David Coombs, a small town doctor at the turn of the century in, believe it or not, Charlestown, Indiana. After the death of one of his old patients the town's newspaper printed a typical article of gratitude: "The Jones family wants to thank all our friends for their solicitude, but particularly Dr. David B. Coombs who had the most to do with our mother's death."

TRAVEL I would like to pay a personal tribute to the officers, trustees, alternate trustees and commission members for their attendance at meetings here in Indianapolis—particularly during last winter's miserably cold months. I never appreciated, nor do I believe did any of us in central Indiana, the extra sacrifice in the hours of travel which it takes for those of you who commute so far to attend our meetings. In traveling our state this past year it was brought home to me many times, and I salute especially those who have done it so often: Eli Goodman, Gib Wilhelmus, Joe Dukes, Vince Santare, to name a few—my hat is off to each of you!

MONEY A quick word about money. Fortunately our reserves and dues structure are quite adequate and our Treasurer, Dr. Popplewell, assures us that no dues increase is necessary. With additional staff being added this year, more than in any of the past years, and with the search continuing for yet another attorney, I sincerely hope Dr. Goodman and the next chairman of the Board of Trustees will carefully examine our escalating administrative expenses and avoid any unnecessary outlay. Embarking on a computer program and the possibility of major legal expenses, should our Malpractice Act be declared unconstitutional, could be a real financial burden.

FRUSTRATIONS I would be less than honest if I didn't admit to a frustration or two. Medical politics, like any other, are apparently necessary but unusually frustrating. Factionalism, regionalism, cronyism and personal ambition are as common in ISMA politicians as in non-medical politicians. It is my strong belief that the delegates (to this meeting) deserve a choice of candidates—from the lowest office to the highest. This body should have the right to choose between at least two candidates. In these difficult times we should utilize this democratic approach to elections.

BLUE SHIELD One of the subjects I

presented to you last year has suddenly loomed as a major problem for ISMA members. Blue Shield executives, in failing to alert their own Board members about a new benefit—vision care negotiated by auto workers and management—has introduced a predicament into our state. As well, Ford Motor Company, through John Hancock, has achieved the same thing.

In years past this association and Blue Shield had fully agreed that Service Plans and panels of participating and non-participating doctors were contrary to our mutual interests. Suddenly to have thrust upon us the latter of these without any advance warning is shocking.

Remember too, however, that the ophthalmologists were aware of this situation but were trying to negotiate on their own and they also are responsible for not alerting ISMA or the Blue Shield Board of this problem. If each of our medical specialties tries to arbitrate separately to its own advantage, certainly my idea of a solid ISMA 5,000-member united front is hopeless.

These events of the past year, negotiated third-party contracts obligating physicians' services, illustrate the dilemma that physicians serving on the Blue Shield Board now face. The potential for a conflict between sound medical principles and prudent business judgment becomes more apparent with expansion of business by Blue Cross/Blue Shield. Moreover, the judgment of those physicians who officially participate on the Blue Shield Board is being questioned and criticized by their physician colleagues.

Therefore, the continued official representation of Indiana physicians on the Blue Shield Board needs to be reviewed and I urge the establishment of an ad hoc committee, appointed by soon-to-be President Goodman, to consider the possibility of severance of relations with Blue Shield. This committee, in its reevaluation of our present commitment, would consider the termination of ISMA-nominated members for appointment to the Board of Blue Shield.

NATIONAL HEALTH INSURANCE I feel it is imperative that this body of representatives of medicine take a firm position on what we, as an organization, can do about National Health Insurance. We can't turn our back on it and expect it to go away. In recent testimony before HEW's Committee on Financing NHI, I presented two alternatives that deserve your attention.

They are: (1) To encourage the private health insurance industry to design a health insurance program that would be similar to the way life insurance is written. If the individual remained healthy, he could receive a cash settlement, or some type of paid-up health

insurance policy, or a combination of the two.

(2) Encourage employers to buy a health insurance policy for its employees that would consist of a deductible, which could put more dollars in the employee's pocket. This money could be saved for future health care expenditures or used to buy other necessities.

(3) Continue to use Federal tax money for the indigent and the elderly.

The only way medicine is going to stem the tide of a federal health insurance program, as I see it, is to prove that we have the better proposal. And to do that, I think we need to get the people and industry behind our solution. In other words, reward Americans for staying healthy. I see no reason why it cannot be accomplished.

And, while I am talking about the federal government's intrusion into medicine, I would like this House to consider a *permanent committee on immunization*. In the past this area has been the responsibility of an Ad Hoc Committee named by the president, but with the government's continuing involvement in this area, I think it is time ISMA had a permanent committee of knowledgeable people to deal with these problems. It could function as a sub-committee of the Commission on Medical Services.

(ASIDE: Federal fiasco on swine flu; mandatory school immunizations)

CONCLUSION During these next two and one-half days let us listen and let us express ourselves as members of this great profession on the problems brought before us.

The past year, in fact two years, of my stewardship to you and the ISMA have been defeating at times while illuminating; depressing while educating; irritating but most refreshing; but, above all, satisfying to me and, I trust, acceptable to you. Thank you for allowing me to represent you.

Address of President-Elect Eli Goodman, M.D.

ACTION: Referred to the Board of Trustees

President Beeler, Distinguished Guests, Fellow members;

This address is going to be quite short, through a misunderstanding of timing, my address is presently being typed down the hall, therefore, I will be brief. I do have a little outline with me of the things that I think are of concern and will go through them quickly with you.

I think we need to begin a campaign to increase the membership in our Association. In order to do this, we must try to bring to the attention of all the physicians of the state of Indiana the many benefits that are available to mem-

bers of our Association. A suggestion has been made that I think might be worth looking into. It is to create a little pamphlet which would put into ONE folder an enumeration of all the benefits that are available.

We need to get into our Constitution and Bylaws and spell out once and for all membership for students, interns and residents. That's a loose end that I think John has mentioned a time or two and I think we need to include it this year.

I want to say a bit about our lobbying. I think we have been blessed with some very fine lobbying service and I think we have had some fine successes and I think we have had a great deal of help from a number of people that I see on the floor here, such as Dr. Lamkin. I do think that we need to do a little research so that when an issue comes up, we won't have to just grab for the material about it at that time, but that we will be prepared and can bring the issue right on out.

I think we need to set-up at the state level a committee of knowledgeable physicians who are close to Indianapolis, who would be readily available for our legislative people, Rick King, and the legislature, and who would immediately bring appropriate and learned testimony about any particular issue.

At the national level, in the last couple of years we have increased our efforts to visit with and maintain liaison with members of our congressional delegation. Don Foy has maintained, I know, communication with staffs of the Congressmen and Senators. I think this is good, I think we need to keep it up. I think we need to get into the offices of the congressional people and the senatorial people at their home bases here a little more than we have been doing.

Now to the structure of our commissions and committees and ad hoc committees, John, you made a suggestion or two that I will certainly look into and try to carry out. I shall make an effort to keep the committees and commissions as streamlined as possible. I should like to keep down as much as I can the appointment of any additional special committees, because this can strain our budget.

To say a bit about computers—in the last couple of years your Board, your Executive Committee, your officers and your staff have given a lot of time to studying computer capabilities. There has been some money funded for that, and I think it's moving pretty nicely. We are developing in-house computer capabilities at this time to be able to maintain accurate records of the physicians of the State of Indiana. We are in the process of negotiating contracts with some other agencies that might help us with the revenue end of this particular thing, and I hope that one day the maxim, "He who controls the data, con-

trols the ballgame" may work to our benefit. I hope we may be in a position to retain not only physician data, but the confidential components, at least, of patient data.

A word about the convention. I think the convention is an extremely important component of our State Medical Association structure. I think we must continuously study and revise and improve as best we can the quality of our Annual Convention. We are having some excellent programs. I hope that we will continue to present an excellent opportunity for education. I want to digress here for a minute to remind this House that it has mandated us, every-time it has spoken, not to permit making continuing medical education compulsory, but to remain voluntary.

We are on the threshold of some activity about sports and medicine. We have put some seed money into trying to develop a Sports and Medicine Program throughout the state.

I have said in the past that PSRO is repugnant, and I have not changed my mind about this. It is repugnant. This House several years ago (I think it was in 1973 or 1974), after action at the AMA level which said that while AMA was going to appoint a committee at the national level to try to keep PSRO in line, directed a viable alternative to PSRO to be developed. A not-for-profit corporation, I-MEDIC was developed, but somehow or other we have not gotten the job done. If there is but one thing that I want to stress in my talk with you this day, it is that we are going to have to develop some kind of foundation to do peer review for third parties.

The liability insurance subject has been covered very thoroughly for you. We have put a little effort and a little money into the matter of countersuits. I don't know where we stand with that now, but we all know that nationally there have been a few successful countersuits, and we want to apply the principles involved in them.

I know that I am following some very, very excellent people, when I become your president. I hope that I will be able to do as good a job as I have seen being done before me.

Address of Governor of the State of Indiana, Otis R. Bowen, M.D.

ACTION: Standing Ovation

My task this morning is a somewhat difficult one. My job is to stimulate the opening of your final session. That's a little like being called in to pitch the final innings of the seventh game of the World Series, when all you have to face

is Dimaggio, Gehrig and Ruth. However, I shall try.

Your meetings this week have been steeped in federal jargon, and heavily weighed with issues being contended in Congress, the murky depths of one or another federal bureau, on the battlefield of some federally prescribed playing field. The fact that more-and-more of America's health care professional meetings find themselves devoted to governmental issues, indicates—unfortunately—the direction our society seems to be headed.

We can . . . should . . . and *must*, speak out against bureaucratization of American health care, when we see the effort lowering the quality, quantity and availability of care to our citizens.

As physicians, we must continue the effort to understand and effect the public policy decisions which will govern our ability to practice freely, and to the best of our individual abilities.

There is no doubt that there is substantial sentiment among many elected to the United States Senate, and to the United States House, to drastically alter the delivery of health care services to Americans by force of federal law. By-and-large, their goals are the same as ours . . . their aspirations for overall improvement of America's health care are no less lofty than ours. It is rather the effect of the bureaucratic machinery that they would seek to impose upon us . . . upon the taxpayer . . . and upon the patient, that separates the two of us.

We have heard that hospital cost containment legislation could well emerge as federal law from this session of Congress. The form of that legislation is all important, for much of what is currently under consideration would remove nearly all meaningful input from local providers, local patients, and locally elected public officials.

National health "insurance" is apparently less of an immediate certainty—but it too seems to be less a question of "if", and one more of "when." This issue as well is one that is hard to oppose fundamentally, for clearly cost factors do adversely affect health care for many of our citizens—especially our elderly.

But though it is hard to fight the concept, there is little to encourage any of us by way of success that government has previously had with many of its earlier efforts to deal grandly with major national problems.

Social Security "insurance" is giving every indication of being neither insurance, nor financial security for one's retirement years.

Nationwide housing efforts proudly launched just a few years ago, today largely stand as expensive but vacant and vandalized monuments to bureaucratic failures of the same type that are now being touted for American health care.

Certainly, answers to these tough

questions must be found.

Assuredly, health care costs must be held in line with what our citizens can reasonably afford.

Truly, unnecessary duplication of high cost facilities, and programs, must be curtailed if we are truly to hold costs in line.

But if the method we as Americans seek to employ to gain these wholly laudable goals, so completely fractures the free and dedicated practice of the health care professions that they become as regimented as those delivering welfare, we will have sacrificed the very strength and vitality of our system in the pursuit of goals that would have been attained in other fashions!

Americans must not allow the delivery of health care services to become the postal system, the H.U.D., or the Social Security fiasco of the '70's!

It's going to take a lot of hard work on our part as physicians. It's going to take an attitude of hard work and openness to change that many feel we are opposed to give. I do not at all believe that we cannot work within a sound system to gain these worthy goals, and yet retain the type of vitality and freedom that we need to assure the high caliber of American health care system that all of us seek.

But the job is a tough one . . . the time is short . . . and the effort substantial. We must try our best.

Thank you.

Address of Auxiliary President Mrs. John Stanley

ACTION: Filed.

Dr. Beeler, Dr. Goodman, trustees, members and guests of the State Medical Association: I would like to take this opportunity to thank Dr. Beeler, Mr. Foy and the Board of Trustees for the help they have given to the auxiliary this year.

I have used the Past, Present and Future—spanning the years—bridging the present with the future—as my motto this year. We have a good foundation already built, now it is our job to build cornerstones.

The idea of unity has been foremost in my mind this year. It is very important that we represent the ideals and concerns of the entire membership. Unity in working together as volunteers at the state, county and individual levels for the common cause of medicine and in assisting our physician spouses in reaching into the community to inform patients that the aim of the physician is to provide the best available health care at the lowest possible cost. To do this, we need members.

MEMBERSHIP—I just received a letter from Betty Hebner of White

County, Monticello. The six-member auxiliary wanted to become inactive and drop their state membership. I wrote to Betty and told her the members may become members-at-large, retaining all the privileges of the *Hoosier Doctor's Wife, Facets*, newsletters and voting. I regret losing this county, but if we can encourage all physician spouses to become a member of one of our three classifications, that is the first step. We then have a name and address to contact for Leggs alert and other pertinent information. You gentlemen may also help by encouraging your spouses and other member spouses in your district to become auxiliary members. I hope our efforts to reach the grass roots land (individual and county) will provide a broader base for representation on our board.

LEGISLATION—We have another Leggs alert out as of last week. On HR 6575 Hospital Cost Containment Act. The state legislative co-chairmen send the information to all county presidents and legislative chairmen. Then the counties contact the individual members to write a letter. In my county for the last two alerts we held several coffees and wrote letters to our congressmen and others on the commission. We will again have Legislator's Day, hopefully, in January this year.

DUES—Our dues this year will be \$2.00. We added a new category of Junior Membership at \$3.00 to accommodate the medical students, interns and resident spouses. So far we have no male members. The board noted that these member spouses could or could not be a member of the ISMA. Each county will be governed by their bylaws as to membership. It was our feeling that there was a need for personal contact with these young people and a need to familiarize them with our programs.

BUDGET—Is always a problem and we are grateful for your support. I will recommend to my executive board to eliminate several of the state chairmen because of overlapping of duties and inflation.

SPECIAL TRANSACTIONS: CPR. A film on CPR will be shown on Tuesday about the Evansville program. We have encouraged each county to have a special session for their auxiliary members to become certified. After all, who is going to take care of you if you become ill at home or on vacation?

Dr. Goodman requested an auxiliary liaison to be on the legislative, convention arrangements and public relations commissions. To date, I have been unable to fill the public relations commission position, but hopefully I will do so within the next few days. We are grateful for the opportunity to attend these meetings.

DUAL BILLING—A committee was appointed and met last month. They sent

out a survey to the counties for their recommendations. The committee will meet again in January and make some recommendation to the membership at our House of Delegates in April.

JOINT MEETING—In July the auxiliary executive committee passed this motion: "We consider a joint House of Delegates meeting with ISMA in April at various locations throughout the state." In our survey we found the spring was the most ideal time for our meeting. The auxiliary members have even asked that our workshops be held in the spring. For this meeting we have planned two days of activities for the wives of the attending physicians. A little social, the tea, the museum tour, our business board meeting, and an educational workshop on personal safety and rape and our 50th anniversary luncheon. I would like for you to encourage your spouses to attend one or more of these functions.

However, we would be most happy for you to try an April meeting jointly with us. We coincided with National on the fiscal year and the changing of chairmen. This eliminates some of the confusion of overlapping officers.

IMMUNIZATION—The auxiliary executive committee met with Dr. Parr to formulate some recommendations for the auxiliary. We can not participate without your approval and guide lines. We will cooperate with the commission in compiling statistics from schools as soon as the legal aspects have been settled.

IMPAIRED PHYSICIAN—Mr. Sullivan provided me with a news release we will use in our December *Hoosier Doctor's Wife* so the auxiliary membership will be aware of this new commission. We will be happy to serve in any way.

Address of Chairman of the Blue Shield Board, Joe Black, M.D.

ACTION: Filed.

Mr. Speaker, Presidents Beeler and Goodman, delegates, members and guests: This year's Blue Shield Board Chairman's Report to the ISMA House of Delegates is titled "30 Years of Progress," to commemorate three decades of service to the people of this state.

That Blue Shield of Indiana has grown and prospered is a tribute to the farsighted action of the ISMA, its members and to the dedicated people who serve as members of the Board of Directors or administrators of the Plan.

I would like to extend personal thanks to John M. Paris, M.D., who has served so well as both a Blue Shield Board member and, most recently, as vice-chairman of the Board. He has contributed a great deal to the success of the

corporation since he was first elected in 1957.

During its life, Blue Shield of Indiana has served both the medical profession and the general public. We have striven to maintain and enhance that unique bond of trust between the physician, the patient and the medical insurer.

The growth of Blue Shield is testimony to our effort to fulfill the trust you have placed in us. I can assure you that Blue Shield of Indiana will make every effort to deserve your continued faith in the future.

Printed Report of Blue Shield Chairman

ACTION: Distributed and filed.

Address of President, American Medical Student Association, Indiana Chapter, Gary Lemmon

ACTION: Filed.

I would like to preface my remarks by expressing appreciation for being offered the privilege to address the ISMA about the organization which I represent, AMSA (American Medical Student Association). I also wish to acknowledge the Marion County Medical Society's allowing my participation at their recent meetings.

As president of the local chapter of AMSA, my duty in reporting to you is two-fold. First, I shall try to convey in a nutshell some of the concerns of national AMSA which you will be discussing in resolutions presented on the floor. Let me caution you for the moment in emphasizing that all national policies are not thoroughly endorsed by the student body of the local chapter. Second, I will explain the current functions of the local chapter.

Opportunities abound for the members of AMSA to become involved in having a say molding present and future policy regarding patient care-physician relationships. Permit me to quote from the Preamble of AMSA to exhibit this point:

"We believe that access to basic health care is a right, not a privilege. This implies equal access to minimum standards of health care regardless of economic status, cultural background, geographic position, race, creed, national origin, age or sex. Since resources are limited they should be allocated so that they equitably promote the public health; thus, health care issues must be addressed in the public forum."

As can be ascertained from this broad definition, any topic even remotely related to medicine is fair game. For sake of brevity, I will present only those

topics of immediate interest.

1) **Mandatory Service:** AMSA supports the concept of voluntary service (minimum of two years) by all physicians in areas of need, providing tax exemptions, financial support, etc. are proffered. It opposes compulsory government regulated service, but believes all students should be at risk and receive financial support should such service be imposed.

2) **HMOs:** AMSA opposes the concept that fee-for-service is the only system that provides highest quality and availability of medical care and therefore supports the concept of pre-paid group practice with the development and funding of HMO's.

3) **PSRO:** AMSA supports the concept of peer review as mandated by Public Law 92-603 with the following recommendations of flexibility so as not to restrict alternative systems, continuing education given greater emphasis than punitive controls and that sufficient evaluation of the PSRO system be undertaken before its extension to the private practice.

4) **NHI:** AMSA supports NHI extending quality health care for all providing such program includes emphasis on preventive and ambulatory care services, multi-source financing including progressive taxation, phased implementation for smooth utilization, catastrophic illness clause and compulsory financing of NHI by individuals, with optional participation of services and choice of physician provided.

5) **Abortion:** AMSA supports sterilization and abortion as acceptable forms of birth control upon acquisition of totally informed consent by the individual to the physician without interference of any third party.

National AMSA offers many other benefits to its members, but I will restrict these to how they affect the local chapter. A local member of AMSA is entitled to the monthly journal *The New Physician*, and a periodic newsletter *Infusion*. Opportunities for AMSA members are available in the MECO program to participate after the first year of medical school with community-oriented practices in the summer. Special discounts are available to members, such as group life and disability insurance, through a unique policy with Minnesota Mutual. Other provisions include a 25% discount on the Frank Netter Ciba-Geigy Collection of Medical Illustrations and a greater than 50% discount on Stedman's Medical Dictionary.

The local chapter is still suffering from a few doldrums that preceded us from former chapter officers. However, idealistic attitudes have once again captured the fire which fuels every worthy organization, and new proposals are being introduced. For incoming freshman members, AMSA prepared an informational

booklet describing courses, books, educational and social environment they would be deluged with in that most important first year. A student directory is being prepared by AMSA listing all students enrolled in the med school. A new information service will be presented to students in a summary form concerning national topics that will have an impact on our future. This is to be implemented in November along with a polling of students concerning these issues. The poll will be compiled and enable chapter officers to better represent the student body at the national convention. AMSA is offering a VD education program to local high schools that will consist of volunteer med students willing to lecture high school classes about the education, prevention and treatment of venereal diseases. This program is currently under review by the State Board of Health and is awaiting approval. Future COPE programs (Community Outreach and Patient Education) will be dependent upon the outcome of this initial step.

New policies will, we hope bolster AMSA's image with both the medical school and the community. With chapter officers Bill Miller, Rick Kohr and Fred Henney supporting these measures, I'm positive AMSA's future has become brighter.

Reports of Officers

Report of Executive Director Donald F. Foy

ACTION: Filed.

In making this second report to the House of Delegates and members of ISMA, I am pleased to relate that the financial condition of the Association continues healthy, as reflected in recent operating statements. This is partly because membership is at a level above budgeted projections while expenses have remained below budget. A detailed financial report will be presented by the Treasurer at the ISMA annual meeting. During the annual audit conducted by George S. Olive Company last October we requested they present us with a management letter setting forth recommendations for strengthening internal financial and management controls. Practically all the recommendations contained in this management letter have been implemented.

Reflecting further on the important events of the past year, I think it appropriate to report to you some of the administrative changes and actions that have taken place. ISMA has hired a full-time legislative analyst. This individual

is a young attorney who represents ISMA in the state legislature, in addition to our two professional lobbyists. His other duties include handling corporate matters, formulating testimony on both state and national legislation, coordinating ISMA's new countersuit program and providing legal advice to members where appropriate.

A third fieldman is being phased into the operation in order to bolster efforts and more adequately exercise surveillance of the HSAs. Accordingly, territorial responsibilities are being revamped to coincide as closely as possible with the three Health Services Areas.

With the concurrence and support of the Board of Trustees, IMPAC has recently employed the services of a full-time staff man whose principal function will be to stimulate physician involvement in the political process through political education. At the outset, priority will be given to membership development and it is thought that increased membership will more than offset the added cost of his services. Reporting and record-keeping have become burdensome under the new FEC regulations and this is an area which merits staff support.

Revised personnel policies, approved by the Executive Committee, were distributed to all employees. Job descriptions for the entire staff are still in the process of development, due to continuing realignment of functions.

Progress has been made toward improved communications through: (1) A special Information Bulletin for the Board of Trustees and leadership, distributed periodically. (2) Publishing the *News Flash* on a more regular basis. (3) Distributing a Summary of Board of Trustees actions to the entire membership following each Board meeting. (4) The establishment of an information clearinghouse at ISMA headquarters to facilitate the participation of physicians serving on HSA Boards and Subarea Advisory Councils in the three Health Services Areas. In addition Legislative and PAC newsletters are being planned by staff.

Unfortunately, the Tel-Med program was discontinued in June due to lack of funds with no prospect of additional funding from outside sources. ISMA will continue to maintain the franchise and offer interested county medical societies the opportunity to utilize the equipment and program in their respective locales. Blue Cross-Blue Shield has expressed interest in co-sponsoring the program with ISMA and is currently assessing costs.

The Future Planning Committee can boast of two major achievements over the past year—completion of a feasibility study on computer applications and the conduct of a membership opinion poll, the results of which have been reported to the Board of Trustees and appropriate action taken.

After a thorough study of the health insurance marketplace, the Board of Trustees decided to retain Blue Cross-Blue Shield as the carrier for the ISMA-sponsored members' health insurance program. An improved benefit structure was negotiated and descriptive literature will be mailed to all those enrolled. The Blues have also assigned a knowledgeable person to the ISMA program to handle all inquiries and expedite complaints.

At its July meeting the Board of Trustees will be exposed to the AMA-structured basic seminar on negotiations. Increasing third party intrusion into the practice of medicine makes it imperative that organized medicine be prepared to send skilled representatives to the bargaining table with its demands.

Discussions are underway with the Medical Licensing Board to provide them with required computer services which, hopefully, will avoid future problems associated with the periodic registration of licenses.

A concerted effort has been made this year to provide testimony and comments on proposed national legislation and regulations as a supplement to AMA's activities. It is no secret that Indiana's congressional delegation is much more receptive to receiving comments on key health issues from voting constituents than from sources outside of Indiana. Moreover, federal regulations and legislation possess the potential for exerting greater influence on the practice of medicine than that which is generated at the state level.

Although the next session of the General Assembly is scheduled to be a short session, I am sure it will not be short on legislative challenges. The chiropractors will undoubtedly again be seeking their own separate licensing board and an expanded medical role. A certificate of need bill will almost certainly be introduced, which may or may not include physicians' offices, and will probably depend upon our ability to influence the development of such legislation. We should anticipate a movement by the optometrists to seek approval to use drugs for therapeutic and diagnostic purposes, thereby expanding their scope of practice. Similar legislation exists in West Virginia and North Carolina.

The Medical Licensing Board has propounded rules and regulations to implement the new Medical Practice Act. Included in these new rules and regulations is a continuing medical education requirement tied into the re-registration of licenses. The Board intends the requirement to be voluntary at the outset but to eventually become mandatory. Public opinion, or, more precisely, what legislators think is public opinion, looms as an important consideration for ISMA in any discussion of mandatory CME.

Consistent with his inaugural promise, ISMA President John W. Beeler has appointed a Committee on the Impaired Physician. The chief purpose of the committee is to devise guidelines and methods for identifying physicians with various disabilities and persuading them to seek help. The committee intends to serve as an intermediary between the functioning impaired physician and the Medical Licensing Board. In order to facilitate this relationship, a member of the Medical Licensing Board has been appointed to serve on the committee. The committee has met several times and is making significant progress.

The Board of Trustees has approved the holding of a major conference on Rising Health Care Costs. Such a conference would include leaders from organized medicine, labor, industry, insurance, hospitals, etc. The principal focus of the conference will be on identifying effective private sector mechanisms for dealing with rising health care costs. The project has been referred to the ISMA Public Relations Commission for implementation.

Today, most trade associations are prospering as never before. The forward-looking associations are providing interpretation and facts, moving out ahead on issues, anticipating problems and trends. A heavy emphasis is being placed on the intelligence function in-depth analyses, providing government with hardheaded, credible information for its decisions and at the same time feeding back information to decision-makers. The trade associations that are growing fast are dynamic and aggressive, feistier and out front—digging into technical matters with competent staffs. This is the image I want for ISMA.

Lobbying is changing in line with the new type congressman. The effective lobbyists are those with know-how—those who make sense because they offer expertise in their industry and have credibility. Good ole boy lobbyists who relay on cronyism are becoming anachronisms. This is one reason for Big Labor's lack of success with the present Congress, since some of the unions are still lobbying in the old way.

The importance of wider personal involvement at all levels—county, state, specialty society and national—cannot be over-emphasized. Imagine how much stronger organized medicine could be if only each current member brought just one colleague, who does not now belong.

Members should look on their association as an investment—of time and money—use its services, facts and data, technical assistance, government relations, etc. If you have not been satisfied with results thus far, why not get involved and work from within for necessary changes. You have a lot at stake.

DONALD F. FOY
Executive Director

Report of Treasurer Arvine G. Popplewell, M.D.

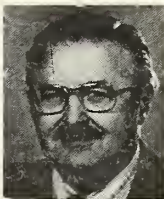
ACTION: Accepted subject to final certification of audit.

A detailed report of the financial condition of the association at September 30, 1977, will be made available to the reference committee prior to the annual meeting.

As was done last year, I am presenting an unaudited report of the financial condition as of May 31, 1977, and the figures from the Sept. 30, 1976, audit, for comparison. I hope in this way it will give our members a more current review of the financial condition of the State Association. At May 31 expenses overall are well within budget.

ARVINE G. POPPLEWELL, M.D.
Treasurer

First Trustee District



BERNARD B.
ROSENBLATT, M.D.
Trustee

ACTION: Filed.

The First District Medical Society held its annual meeting on May 19 at the Evansville Country Club. The winners of the second Bob Acre Memorial Golf Tournament were Dr. John Tisserand, who won Low Gross in an exciting play-off with Dr. Bill Ritchie, and Dr. Dennis Hodge, a resident physician at St. Mary's Hospital, Low Net.

A report to the membership from ISMA called attention to the Public Relations Commission's plans for a conference on health care costs and to employment of Mr. Rick King as legislative analyst, and an employee for IMPAC. Information was also supplied on the current status of medical liability insurance in Indiana and on a feasibility study of in-house computer capability for the Association.

Dr. Ralph Carlson, First District Trustee to the Indiana Blue Shield Board of Trustees, reported that Indiana Blue Shield is considering entering the dental insurance business. Dr. Carlson also noted that the Federal Trade Commission has subpoenaed information from Blue Shield, and a law firm has been retained to deal with the FTC.

INDIANA STATE MEDICAL ASSOCIATION Statement of Financial Condition

ASSETS

5/31/77 9/30/76

GENERAL FUND:

Cash on deposit	\$ 125,815	\$ 75,866
Investments—at cost:		
U.S. Treasury Bonds—long term	35,083	35,083
U.S. Treasury Bills, Certificates of Deposit—short term	924,622	558,451
Accounts receivable	39,699	28,740
Prepaid expense and miscellaneous assets	8,995	20,118
Office furniture and equipment—net of accumulated depreciation	20,509	20,812
	<u>1,154,723</u>	<u>739,070</u>

BUILDING FUND:

Cash on deposit	2,311	3,822
Cash in savings account	8,355	8,140
U.S. Treasury Bills	273,412	255,744
Prepaid and deferred expenses	2,055	604
Headquarters property:		
Land	69,188	69,188
Office building and improvements—net of accumulated depreciation	219,753	225,930
Rental properties—net of accumulated depreciation	75,573	77,499
	<u>650,647</u>	<u>640,927</u>

STUDENT LOAN FUND:

Cash in savings account	19,190	19,190
Certificates of deposit	20,810	20,810
	<u>40,000</u>	<u>40,000</u>

MEDICAL DEFENSE FUND:

Cash in savings account	44,160	38,518
U.S. Treasury Bonds	25,300	25,300
	<u>69,460</u>	<u>63,818</u>
	<u>\$1,914,830</u>	<u>\$1,483,815</u>

LIABILITIES AND FUND BALANCES

GENERAL FUND:

Accounts payable	\$ 3,714	\$ 11,933
Accrued taxes	—	473
Dues payable to AMERF	20,825	21,230
Dues payable Counties, Districts, AMA	44,077	—
Unearned portion of current year dues	422,046	186,150
Deferred annual meeting income	—	2,825
Deferred contributions—Tel Med	1,186	3,864
Lease contract payable	477	723
Fund balance	662,398	511,872
	<u>1,154,723</u>	<u>739,070</u>

BUILDING FUND:

Accrued taxes on rental properties	1,043	1,121
Damage deposits and accounts payable	743	686
Loans from members (non-interest bearing)	19,375	19,475
Fund balance	629,486	619,645
	<u>650,647</u>	<u>640,927</u>

STUDENT LOAN FUND:

Fund balance—principal balance appropriated from General Fund	40,000	40,000
	<u>40,000</u>	<u>40,000</u>

MEDICAL DEFENSE FUND:

Fund balance	69,460	63,818
	<u>69,460</u>	<u>63,818</u>
	<u>\$1,914,830</u>	<u>\$1,483,815</u>

Dr. Gilbert Wilhelmus reported for AMA in the absence of Dr. Corcoran and called attention to the fact that Dr. Corcoran is running for re-election to the AMA Council on Medical Education at the annual AMA meeting in June. Dr. Wilhelmus also reported that he had been named by ISMA, along with Don Foy, to become educated in the art of negotiations and that he would be attending an advanced seminar soon.

In the election of officers, Dr. James Marvel was elected First District president for the coming year, with Dr. Forrest Radcliff chosen vice-president and Dr. Frank Hilton secretary-treasurer. Dr. John Bizal was elected trustee to the Indiana State Medical Association.

As retiring Trustee, I was most gratified when a resolution was presented to the District which had previously been adopted by members of the Vanderburgh County Medical Society, and which recognized my years of service as ISMA trustee and alternate trustee from the First District. It has been both a privilege and a pleasure to serve my colleagues in this fashion, and I am indebted to them for choosing me to represent them.

BERNARD B. ROSENBLATT, M.D.
Trustee

Second Trustee District



PAUL W.
HOLTZMAN, M.D.
Trustee

ACTION: Filed.

It has been my distinct privilege to serve yet another year on the Board of Trustees.

Orchids to the staff and those officers of the Association who are diligently and thanklessly working for the benefit of ISMA. Orchids also to those members who are slowly realizing the value of ISMA and AMA.

Onions to those who are still unaware of the fact that they have in their grasp, *the greatest union on earth.*

PAUL W. HOLTZMAN, M.D.
Trustee

Third Trustee District



THOMAS A.
NEATHAMER, M.D.
Trustee

ACTION: Filed.

This past year our main concerns have

been with the malpractice law, National Health Insurance, PSRO and Blue Cross and Blue Shield. I am very sorry that I cannot report that we have made very much progress in any of these areas. National Health Insurance still appears to be on the horizon for the practicing physician.

Indiana stands particularly alone in opposing any type of National Health Insurance. At the last delegates' meeting, due to the decision of the Board of Trustees, our delegates definitely testified against any form of National Health Insurance. The malpractice law so far has been working quite well. There is now a test case in process to determine its constitutionality; however, this case has not gone far enough to have any definite decisions made on the law.

PSRO is still in progress throughout the state; however, it has been progressing much slower than the Federal Government had anticipated and some of the PSRO members in Indiana, I am sure, would like for it to progress faster. However, there is still no functioning PSRO in our district. Blue Cross and Blue Shield have caused some problems throughout the year; however, the Board of Trustees has kept open lines of communications and several minor problems between Blue Cross and Blue Shield and the physicians have, I think, been resolved satisfactorily. I hope that next year's report will be somewhat more optimistic than this year's. I have attended most of the Trustee meetings and will continue to do so, keeping the district's views in mind whenever we have an issue to vote on.

THOMAS A. NEATHAMER, M.D.
Trustee

Fourth Trustee District



HOWARD C.
JACKSON, M.D.
Trustee

ACTION: Filed.

The Fourth District Medical Society met at the Dearborn Country Club on May 5, 1977. The men played golf and the ladies visited the race track in Cincinnati. Dr. Brockton L. Weisenberger of Columbus presented an interesting scientific talk on "Occupational Medicine." Mr. Ray Richardson of Martinsville presented the evening program, which was well attended and well received.

At the business meeting Dr. Howard Jackson of Madison was elected trustee for another three year term. Dr. Larry Williams of Madison was elected president of the Fourth District Medical So-

ciety; Dr. Brockton Weisenberger was elected vice-president and Dr. Ott McAttee of Madison was elected secretary-treasurer. The 1978 district meeting will be held on May 24 at Madison.

Dr. John Beeler, president of ISMA, Dr. Eli Goodman, chairman of the Board of Trustees, and Mr. Donald F. Foy, executive director, were guests of the Fourth District Medical Society at our meeting.

As your trustee, I have visited some of the county society meetings but, unfortunately, not all. I have sent out reports after each Board meeting and also on other important occasions. Of course, we have been preoccupied with government interference into the private practice of medicine, as manifested by PSRO and HSAs in the past year. Now we must turn our attention to continuing medical education, what with many legislatures and state medical associations looking at requiring a yearly quota of continuing medical education for relicensure and membership, respectively. I am at the present polling the members of the Fourth District Medical Society as to their views regarding this issue.

HOWARD C. JACKSON, M.D.
Trustee

Fifth Trustee District



CLEON M.
SCHAUWECKER, M.D.
Trustee

ACTION: Filed.

Although I have not searched the Archives, I believe I can safely say that the Fifth District can report a "first" since its inception. Ground was broken for two NEW hospitals this spring. Being from Greencastle, and nearing the end of my second term as trustee, I shall report on Putnam County first. Ground was broken this spring for a new hospital to replace the present structure. It will be located approximately three miles south of Greencastle on State Road 231. As to the time of completion, many dates have been given, and later "un-given." The safest bet is "in the vicinity of two years."

The new hospital at Terre Haute had groundbreaking ceremonies in June for the Terre Haute Regional Hospital. Actual construction is slated for August. It is to replace the former St. Anthony's Hospital and will be located on the south side of Terre Haute. Union Hospital at Terre Haute was also extensively remodeled with a new labor and delivery suite, a new intensive pediatric care unit and new intensive care unit for adults.

The Fifth District held its annual meeting at the Holiday Inn south of Greencastle on May 18. Attendance was good. Among the guests were Dr. John Beeler, Dr. Eli Goodman, Dr. Malcolm Scamahorn, Mr. Don Foy and Mr. Bob Amick. During the business meeting, an informal vote was taken as to the members' attitudes concerning "compulsory" relicensure. The vote was almost unanimous in opposition. However, the feeling was almost unanimous in favor of "voluntarily" stressing the importance of and the necessity for continuing medical education.

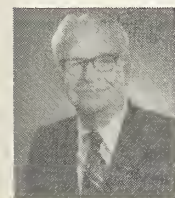
The speaker, Dr. Daniel S. Giroux of the Argonne Laboratories, was well received. He spoke on the atomic energy and other energy problems. It was presented in a delightful and entertaining manner and was quite humorous.

The officers elected for the coming year are: President: Dr. Frank Swaim, Rockville; vice president: Dr. Richard Bloomer, Rockville; secretary-treasurer: Dr. Clyde Jett, Terre Haute.

The tentative plans are for the 1978 meeting to be held at the Terre Haute Country Club on May 3.

CLEON M. SCHAUWECKER, M.D.
Trustee

Sixth Trustee District



GLEN WARD LEE, M.D.
Trustee

ACTION: Filed.

The Sixth District Annual Meeting was held at the Greenfield Country Club on May 11, 1977. Mr. Richard R. King, legislative analyst for ISMA, gave a report on current status of "State and National Legislation." Mr. Donald F. Foy, executive director for ISMA, gave an update of the activities of the association, and Dr. John Beeler, president, gave a report on his activities and questions he is encountering in representing the State Association. Also, Mr. Herb Dixon, from Blue Shield, reported on the changes in our Comprehensive and Major Medical Insurance, and asked for reports of any problems. Dr. James Harshman, Kokomo, chairman of the Board of Trustees, gave a report of the activities of the board. Time and effort of all of the above to participate in our meeting were greatly appreciated.

Mr. Robert Amick, of our field staff, promised that a visitation to each of the County Societies in the Sixth District will be made in the next year and Dr. Glen Ward Lee, trustee of the Sixth District, will accompany him on these

visits when possible. The meeting was attended by 36 people and the presentations were made so that a round table discussion of the matters brought up could be had. This format permitted free discussion and was enjoyed by all the participants.

The business meeting was held at 4 p.m., presided over by Dr. C. G. Clarkson of Richmond, president of the Sixth District. Dr. O. L. Webb, New Castle, was elected our new president for 1978. Dr. Hal Rhynearson, Fortville, was elected president-elect. Dr. C. V. Sage, Richmond, was nominated for the Blue Shield Board from the Sixth District. Dr. Glen Ward Lee, Sixth District trustee, asked for reports of any problems arising in the County Societies of the district and pointed out any requests for change in membership status must be approved by the County Societies and submitted to Dr. Lee before it can be submitted to the ISMA Board of Trustees for consideration. A special form for this purpose will be furnished to any County Society secretary upon request.

Cocktails and dinner were by courtesy of the Sixth District Medical Society. Dr. Joseph A. FitzGerald, director, Outpatient Clinic at Larue Carter Hospital, entertained the audience with a talk entitled "Adjusting To Being Single Again." Next year's meeting will be held in Shelbyville at a time to be decided later.

Subsequent to the meeting, Mrs. William R. Tindall, Shelbyville, was renominated from the Sixth Congressional District to the IMPAC Board.

GLEN WARD LEE, M.D.
Trustee

Seventh Trustee District



JOHN O. BUTLER, M.D.
Trustee



JOHN G. PANTZER, M.D.
Trustee

ACTION: Filed.

The Seventh District Medical Society is proud of its member, Dr. John W. Beeler, who is now completing a productive and successful year as president of the Indiana State Medical Association. We feel sure that all the districts will want to join the Seventh District in

extending a hearty "thank you" to John for all his work in our behalf.

This year's meeting was held June 8 at the Valle Vista Golf Resort in Greencastle. Despite intermittent heavy rain, several members and wives managed to complete a full round of golf. The meeting also marked the inauguration of an annual tennis tournament for the Seventh District.

Dr. Charles R. Thomas, president, presided at the well attended business meeting. The first item of business was selection of Seventh District officers. Dr. Stephen L. Hardin of Morgan County was elected to succeed Dr. William Stafford as president elect. Dr. Malcolm Scamahorn was reelected secretary-treasurer.

Based on previous action by the District, one ISMA trustee and two alternate trustees were to be elected. Dr. Donald C. McCallum was elected unanimously to succeed Dr. John Butler as Seventh District trustee. Dr. I. E. Michael was elected to a two-year term as alternate trustee to succeed Dr. McCallum. Dr. Gerald Kurlander was elected to a two-year term as alternate trustee to succeed Dr. Paul Muller.

Dr. Muller, who for personal reasons decided not to seek reelection as alternate trustee, received thanks from many of the members in attendance. We feel sure that all the District members will join us in this formal thank you for a job well done. Although, we have lost an able representative, we are pleased to know that we will still be able to turn to Paul for assistance in the future.

It is an apparent concern that future ISMA endeavors should focus on unification of physicians and seek to provide a broader base representation of members. An action in 1968 recognized disproportions of representation and as a result provided the Seventh District with better representation on the Board of Trustees but similar adjustments have not occurred regarding Commissions, Committees, or Reference Committees of the House of Delegates. To continue in this philosophy, the Seventh District has unanimously submitted a resolution to the ISMA House of Delegates which is designed to provide more proportional representation on ISMA Commissions.

The trustees have made an effort to attend the meetings of the County Societies in the District. We have enjoyed this opportunity to meet with our constituency and hope that similar interchange of ideas will take place in the year ahead.

We also feel it appropriate to note that our nominee to the Blue Shield Board of Directors, Dr. B. T. Maxam, has been doing a yeoman's task in that role. We have found Bev open to suggestions and genuinely interested in our concerns. Like your trustees, Bev has

attempted to meet with a number of the Seventh District members in an effort to obtain the broadest base for his decisions. We thank Dr. Maxam for his continued efforts on the Blue Shield Board of Directors.

JOHN O. BUTLER, M.D.
JOHN G. PANTZER, M.D.
Trustees

I would like to take this opportunity individually to extend thanks on behalf of the entire District to Dr. John Butler for his long and dedicated service to physicians of the Seventh District and Indiana. Since 1965, John served on the ISMA Board of Trustees, first as an alternate and then for two full terms as trustee. This past December John also completed a term as a member of the ISMA Delegation to the American Medical Association. He has served capacities too numerous to mention here. In all his roles, he continually endeavored to do the very best for his profession.

To John for all his work, and to Martha Butler, M.D., for her support and sharing: thank you.

JOHN G. PANTZER, M.D.

Eighth Trustee District



JACK M. WALKER, M.D.
Trustee

ACTION: Filed.

The Eighth District Medical Society Annual Meeting was held on June 8, 1977, at the Delaware County Country Club with Delaware County being the host this year. The meeting was well attended by members and guests; and the entertainment, which was provided by Mark Russell, was particularly enjoyable.

The business meeting saw the election of Lowell Painter and Howard Koch to the offices of president and secretary-treasurer respectively.

The next meeting of the Eighth District Medical Society will be held on June 7, 1978, at the Delaware County Club and the meeting will be hosted by the Randolph County Medical Society.

JACK M. WALKER, M.D.
Trustee

Ninth Trustee District



JOHN A. KNOTE, M.D.
Trustee

ACTION: Filed.

Initially, I wish to thank members of the Ninth District of the Indiana State Medical Association for affording me the privilege of representing this area on the ISMA board of trustees.

This report will include a summary of activities of the ISMA board of trustees since October, 1976 and some items for current and future consideration.

The trustees were actively involved (through the legislative committee of the board, in addition to representation on the Legislative Commission) with state legislation and with consideration of national legislation involving medicine.

We opposed the laetrile bill to no avail at the state level. Generic substitution of a prescribed drug did not receive a hearing in this session. Immunity (of physicians) in utilization review passed both houses. Definition of death passed the house, but did not receive a Senate hearing. The physicians' assistant bill passed both houses. A bill to strengthen the medical review panel selection process (for medical liability cases) passed both houses. Most significantly, the bill to separately license chiropractors was defeated, and the certificate of need bill was not passed. All of these bills were at the state level.

On the national level, we are currently very concerned about amendments to the Federal Trade Commission regulations which would give federal interests direct access to physicians' office records. In addition there is concern by the ISMA members at the medical center about a House of Representatives bill which would classify house staff members as employees rather than students. Of course, the overriding spectre of government interference remains the major concern of medical practitioners at this time.

Of national regulations which are affecting us locally at this time, the activities of HSAs and P.S.R.O.s will require our active surveillance and continued attempts to modify those forms of interference to the advantage of patients and physicians.

One additional factor of interest was the correct impression by many local practitioners that Criteria and Standards (and Guidelines) for Areawide Planning of Perinatal Services had been established without proper consideration of obstetrical needs in smaller hospitals outside metropolitan areas. Hopefully, the response of the Indiana State Medical Association Board of Trustees and Dr. Harshman (chairman of the Board) was sufficient to forestall regulations by the State Board of Health which might have hampered obstetrical service in smaller hospitals.

Finally, I have received several complaints about relationship between Blue Cross-Blue Shield and physicians and

between that company and patients. The ISMA Board of Trustees is currently reviewing any complaints that doctors or patients may have regarding relationships with Blue Cross-Blue Shield. Please summarize any such comments and forward them to me in writing.

I hope to have personal contact with more of the district physicians at your county society meetings in the coming year. Please contact me if I can represent you more effectively at the state level.

The 1977 district meeting was held in Monticello with the White County Medical Society as host. Dr. Max N. Hoffman was reelected Alternate Trustee. The 1978 meeting, to be hosted by the Hamilton County Medical Society, will be held in Tippecanoe County.

JOHN A. KNOTE, M.D.
Trustee

Tenth Trustee District



MARTIN J. O'NEILL, M.D.
Trustee

ACTION: Filed.

The last meeting of the Tenth Trustee District was held Sept. 8, 1976, at the Woodmar Country Club, Hammond, with a record attendance of 175 members. The day started with a golf tournament, followed by a business meeting at 5 o'clock, then a cocktail hour and dinner. Mrs. Henry Giragos presented a fashion show at 4 o'clock for the ladies, with Auxiliary members as models. There were 40 ladies present.

Golf winners were: Low gross, Dr. E. J. DeGrazia, Valparaiso; low net, Dr. Michael Allegretti, Hammond; closest to the hole, Dr. Ramon Blanco, Dyer. Mrs. Thomas Wooden had low score for the ladies.

Dr. Joseph Siekierski, Tenth District president, conducted the business meeting, at which Dr. Martin J. O'Neill reported on the District activities for the past year. Dr. Vincent Santare, ISMA president, reported on activities at the state level and reminded members of the State Association meeting to be held in Indianapolis Oct. 9 to 12 and encouraged attendance. The minutes for the June 1975 and January 1976 meetings were approved. Dr. James Brown, Valparaiso, was elected Tenth District president and Dr. B. M. F. Palmer, Hammond, was elected secretary.

Dr. O'Neill presided at the dinner, which was attended by 160 physicians, wives and guests. He introduced Dr. John Budd, president-elect, AMA, Dr.

Lowell H. Steen, trustee AMA, Dr. Vincent J. Santare, president ISMA, Dr. John W. Beeler, president-elect ISMA, Dr. Eli Goodman, chairman ISMA Board of Trustees, Dr. James Harshman, AMA delegate, Dr. Peter Petrich, AMA delegate; Dr. Thomas C. Tyrrell, alternate AMA delegate, Dr. Malcolm Scamahorn, AMA delegate, Dr. Leonard Neal, alternate Tenth District trustee and chairman of the board of Lake County Medical Society, Dr. Lambro Dimitroff, president, Lake County Medical Society, Dr. Joseph Siekierski, president, Tenth District, Dr. James F. Fitzpatrick and Dr. Peter Gutierrez, Indiana Blue Shield Board, Mr. Donald F. Foy, executive director, and Howard Grindstaff, field representative ISMA, and Mr. John Twyman, executive director of Lake County Medical Society. Present, but not introduced due to an oversight, were Dr. Lee Trachtenberg, president, Calumet Area Foundation for Medical Care, and Mr. Charles Shoemaker, the executive director of the Foundation.

Mr. Don Laser of Laser Pharmaceutical Company donated a television set that was given away as a door prize.

The speaker for the evening was Richard "Digger" Phelps, highly successful basketball coach at Notre Dame. He emphasized the necessity of improving the standards of elementary education in order for students to be properly prepared for high school and college and encouraged physicians and their wives to make their legislators aware of the deficiencies in primary education, in order that the necessary improvements be accomplished. Following his talk, he answered many questions pertaining to basketball, players and recruitment.

Lake County Medical Society officers elected during the year were Dr. Lambro Dimitroff, president, and Dr. David E. Ross, secretary. Porter County Medical Society installed Dr. Frank Sturdevant, president, and elected Dr. Charles Griffin, secretary, and Dr. James Brown, president-elect. Dr. Lee Trachtenberg was reelected president of Calumet Area Foundation for Medical Care and Mr. Charles Shoemaker continues as executive secretary.

As Trustee of the Tenth District, I am invited to attend the monthly meetings of the Lake County Medical Society to discuss the activities of the Board of Trustees of ISMA. I miss very few meetings because I find them informative and helpful in making my decisions on questions that come up at ISMA Board sessions. I also attend the Porter County Medical Society meetings. A revision of the Constitution of Porter County Medical Society was made and approved by the society during the year.

The Calumet Area Foundation for Medical Care is now seven years old and continues to meet the challenge of medi-

cine in the socioeconomic sector. The Coordinated Care Program (CCP) under the guidance of Dr. Forrest R. LaFollette has produced a worthwhile study of hospital utilization. At present, all Lake County hospitals, with two exceptions, are participating in the program and an agreement with Inland Steel has been renegotiated for another year. A marketing effort for new company clients has been initiated this year and there are at least two interested companies.

In the area of PSRO, the Foundation continues to be dealing with the Calumet Area Professional Review Organization (CAPRO) during its planning phase. Discussions are under way with the Federal Government to attain conditional status for the area. It is anticipated the PSRO will receive a conditional contract in July or August. Since CAPRO involves Area I—Lake, Porter and LaPorte counties—membership in CAPRO is not dependent upon membership in CAFMC.

I would like to mention that the Tenth District is proud to have in its membership immediate past president and member of the Executive Committee of ISMA, Dr. Vincent Santare; AMA trustee, vice-president of AMA-ERF, and commissioner to JCAH, Dr. Lowell Steen, and ISMA alternate delegate to AMA, Dr. Thomas Tyrrell.

MARTIN J. O'NEILL
Trustee

Eleventh Trustee District



JAMES A.
HARSHMAN, M.D.
Trustee

ACTION: Filed.

As each succeeding year passes, frustration grows concerning the intrusion of government into the private practice of medicine. Never a week passes but what one hears uttered "I'm quitting in a couple of years—I can't stand the bureaucratic paperwork any longer." Indeed this attitude has penetrated to the younger physicians as well as the older ones.

It is increasingly evident that socialists, the federal government, and its agencies are determined to destroy the professions—medicine, dentistry and, to some extent, even the legal profession. Occasionally, two different governmental agencies are on opposite sides of an issue and we are caught in the middle. Recently a high Department of Health, Education, and Welfare administrator advised the Secretary, DHEW, that the supply of physicians should be "constrained" to decrease utilization of health

services and subsequently reduce total expenditures. On the other hand, the Federal Trade Commission has charged that the American Medical Association has been in restraint of trade by limiting the supply of physicians through its accrediting of medical schools!

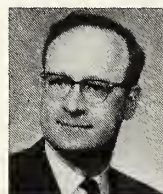
Without question, the "Third House" of government—the bureaucrats and full-time congressional staffs—are in firm control of our government. In addition, they are insulated from public view and scrutiny. Congress has abdicated much of government to this group. Mechanisms must be devised to expose these employees of the federal government and, more importantly, to make them accountable to the public. Too frequently, federal regulations are passed which are contrary to the intent of the original enabling legislation. The liberal attitudes of Congress added to the socialism of federal bureaucrats have accounted for the intrusion of government into our daily lives. This has accounted for the frustration so prevalent in the medical profession.

Never before has the challenge been greater for the leaders of the medical profession to find solutions to the problem of "How to handle the Third House." Our patience is wearing thin and time is running out. Never before has there been a greater need for a strong and unified voice for organized medicine.

Last September, Huntington County was host to the Eleventh District Medical Society in Huntington. The meeting was well attended. Dr. Jose Oller, president of the Council on Medical Staffs, was guest speaker for the evening. At the business meeting Dr. William Dannacher of Wabash was elected president and Dr. Fred Poehler of LaFontaine was reelected secretary. Wabash County will be the host for the next meeting, to be held at the Peru Mississinewa Country Club on Sept. 21, 1977.

JAMES A. HARSHMAN, M.D.
Trustee

Twelfth Trustee District



ALVIN J. HALEY, M.D.
Trustee

ACTION: Filed.

The Twelfth District ISMA meeting will be held Sept. 8, 1977, at the Imperial House Motel in Fort Wayne. The most important business will be the election of an alternate trustee.

Franklin A. Bryan, M.D., has pursued a successful incumbency, with a great

attendance record, diligent pre- and post-meeting work, complete and competent meeting presentations. He has established a reputation of ability with affability. He is the ISMA expert on the medical practice act.

Dr. Bryan will be a candidate for re-election. I wish publicly to thank him for being an able consultant and an effective substitute.

At this moment, the "hot" item concerns compulsory continuing medical education, i.e., education necessary for relicensure or license re-registration. Despite a long participation and interest in CME and despite my current professional medical education practice, I disfavor compulsory CME. I oppose making CME a prerequisite for relicensure or re-registration for the following reasons:

1. Voluntary CME is adequate. The Indiana University School of Medicine is doing a great job with its CME programs and notes greatly increased attendance. The ISMA and its education commission likewise are leading the way in establishing and encouraging valid voluntary programs; so are specialty societies.
2. Presently, no convenient recording system is operational for CME hours.
3. No recording cycle is universally accepted.
4. No problems are solved by compulsory CME, such as the malpractice crisis, the disabled physician problem (alcohol, other drugs, senility), physician maldistribution, governmental and third-party interference, etc.
5. Not enough is known about the educational needs of physicians or how to match individual needs to specific educational content, process, modalities, accesses, etc.
6. No known method exists to show what CME has accomplished or whether it has done what was hoped of it.
7. Compulsory CME may be illegal in Indiana. (The medical practice act doesn't mention it.)

I think that our sister states which have embraced CME for licensure prerequisites have done so thoughtlessly and prematurely.

For Indiana to undertake compulsory CME for the wrong or inadequate reasons would risk throwing operative voluntary CME programs into a "Mickey Mouse" game of providing only hours instead of quality education.

How do you feel about this?

Meanwhile, back in the Twelfth District we currently have a dedicated group of officers, anxious to transport your thoughts and desires to the ISMA.

ALVIN J. HALEY, M.D.
Trustee

Thirteenth Trustee District

G. BEACH
GATTMAN, M.D.
Trustee

ACTION: Filed.

The Thirteenth District meeting was held in Michigan City at the Pottawatomi Country Club on Sept. 10, 1976. The early afternoon activities included golf, tennis and a special ladies' program.

The meeting was called to order by President John Luce. Reports were given by Secretary-Treasurer David Spalding, Blue Shield Representative Kubik and Trustee G. Beach Gattman. Dr. Vincent Santare, president of ISMA, gave a state report, and Dr. John Beeler, president-elect, was introduced. Also present were Chairman of the Board of Trustees Dr. Eli Goodman, Executive Director Donald F. Foy and northern area fieldman Howard Grindstaff.

Dr. Elmer Billings of Elkhart, president-elect of the Thirteenth District for 1977 was present. Election was held for alternate trustee and Dr. Donald Chamberlain was reelected. Dr. David Spalding was chosen president-elect for 1978. Dr. Michael Quinn of South Bend, was elected secretary-treasurer.

Following the business meeting, cocktails and dinner were served and the evening's program was presented by the Greek Dancers from Chicago.

The 1977 meeting will be held at the Elcona Country Club, Elkhart, on Sept. 14. The evening program will be an address by Secretary Earl Butz.

G. BEACH GATTMAN, M.D.
Trustee

Report of Editor of The Journal

ACTION: Filed.

The financial accounts of *The Journal* are almost exactly as predicted by the budget. A deficit of about \$27,000 was expected. At the time this report is written it is estimated that the deficit will be close to \$26,000. Most of the fiscal year was spent with a slight positive balance in the Journal account but the June issue and the Roster Supplement are the most expensive monthly expenditures of the year and this year will account for almost all of the deficit. The \$4,000 grant from Eli Lilly and Company for publication of Medical Grand Rounds was a one-time contribution but will be more than replaced in 1977-78 by a \$6,000 grant from the Continuing Medical Education program of Indiana University School of Medicine which

will support publication of a monthly teaching article.

The improved financial picture in 1976-77 is due to new items of income such as the Lilly award for publication of Medical Grand Rounds, the Sandoz Prize Award and, in small part, to subsidy payments by authors whose articles occupied space in excess of two pages.

Limitation of articles to two journal pages and the subsidy of longer articles does not produce much income. However, the rule has influenced authors to be brief and to condense their writing. The result has been shorter articles which are easier to read and which conserve space, produce a smaller journal issue and limit the printing bill.

Almost all the longer articles which were accepted prior to the space limitation rule have now been printed. The future will see more and more short articles. In the case of review articles and some others which cannot be shortened, the subsidy, which has been accepted by almost all authors, will contribute to the financial health of *The Journal* budget.

"Seminars from Riley Hospital" is being continued on an abbreviated schedule.

Indiana University School of Medicine will produce and subsidize the publication of a four-page continuing Medical Education article each month for an indefinite period. A fifth page containing a quiz and facilities for registering the article for Category 1 credit will also appear each month.

Indiana University is the site of one of the four research centers for the National Institutes of Health program for the investigation of cause and treatment of hypertension. This group of investigators and clinicians will produce a two-page article on hypertension and its multiple aspects for publication each month for a period estimated, at the present time, to be two years or more.

The Journal was the subject of a readership study conducted by David Labson of Health Industry Research. The February 1977 issue was the target. Forty one percent of the 150 questionnaires were returned, a phenomenon which, in itself, is highly complimentary. Readership, both for scientific content and for advertising messages, was high and was rated by Mr. Labson as excellent.

The historical and museum articles by Dr. Charles Bonsett, and several other writings on medical history, have, very adequately, satisfied the historical mission of *The Journal*.

FRANK B. RAMSEY, MD.
Editor

Report of Delegates to AMA

ACTION: Filed.

Officers and the Indiana delegation to

the American Medical Association attended both meetings of the American Medical Association which were held following the October 1976 Annual Meeting of the ISMA. They represented the ISMA in reference committees and in the AMA House on vast numbers of issues which were considered by delegates from every state medical association.

The Annual Meeting of the AMA was held in San Francisco June 18-23, 1977, and the Clinical Conference convened in Philadelphia, Dec. 4-8, 1976.

This report will give a few of the highlights on the Philadelphia Conference and will address itself to more detail on the annual session in San Francisco.

Through the efforts of the delegation, assisted by officers of the ISMA Auxiliary, the delegation was successful in re-electing Patrick J. V. Corcoran, M.D., Evansville, to the Council on Medical Education. Additionally, John W. Beeler, M.D., president of ISMA, who was elected president of the Organization of State Medical Associations' Presidents at the Philadelphia convention, will continue in this post until June 1978.

Additionally, Steven C. Beering, M.D., dean, Indiana University School of Medicine, was elected chairman of the AMA Medical School Section which represents 87 schools, and Lowell H. Steen, M.D., Hammond, member of the AMA Board of Trustees, was elected to the Executive Committee of the AMA.

A total of 5,210 people, including 2,806 physicians, registered for the AMA's last Clinical Convention ever, in Philadelphia.

The five resolutions reviewed by the ISMA Board of Trustees and submitted to the American Medical Association's House of Delegates met with a variety of actions by the AMA House which convened Dec. 5 through 8.

Two of the resolutions were adopted. They asked for mandatory use of hockey helmets by all professional hockey leagues and discontinuance of participation in group insurance programs for any physician not a member of the American Medical Association. This latter resolution also requested that husbands and wives of deceased physicians be allowed to continue their insurance coverage under the AMA group policies.

The one resolution dealing with immunity in utilization review was referred to the Board of Trustees of the AMA. The reference committee in its report stated that they "echoed the concern of the resolution, but had questions as to the practicality of a legislation solution . . ."

Generic substitution of a prescribed drug was amended and adopted. The substitute resolution read as follows:

RESOLVED, That the American Medical Association reaffirm its op-

position to the revision of state laws and pharmacy regulations that prohibit unauthorized substitution of prescription drug products as contrary to the public interest; and be it further

RESOLVED, That all physicians be urged to supplement medical considerations with cost considerations in making the selection of the drug of choice for an individual patient and become well informed about the quality and efficiency of prescription drug products available from multiple sources; and be it further

RESOLVED, That physicians indicate by writing prescriptions by the generic name when the selection of the source may be delegated to the pharmacist.

Resolution 48, also introduced by Indiana, was not adopted but previous action of the House of Delegates on the subject was reaffirmed. The resolution asked that the American Medical Association exert the strongest possible influence on the Bureau of Health Insurance of the Society Security Administration to retain the original concept of the Medicare law and reestablish an equitable payment mechanism for physicians' services. The reference committee pointed out efforts had been under way for some time to carry out the objective of this resolution.

A substitute amendment submitted by the Georgia delegation was referred to the Council of Medical Services and read as follows

"Since division of states into geographical areas for payment purposes under Medicare results generally in lower fees for rural physicians, and since lower fees tend to produce a negative incentive to physicians to locate in rural and thinly populated areas, the AMA should make every effort to remove the statutory and regulatory requirements for delineation of fees according to geographical areas."

Major focus of attention at the meeting was on a national health insurance bill and its introduction by the AMA.

The Indiana delegation, as instructed by the Board of Trustees, voted against introduction, but the House of Delegates of the AMA reaffirmed its support of a bill by a vote of 181 to 57.

As was pointed out, the vote was a convincing victory for the AMA Board and decisive defeat for the more conservative members of the House.

The delegates, in effect, decided that political realities demanded AMA continue to have a voice in the coming debate of NHI—expected to heat up with the advent of the Carter administration and a Democratic congress—rather than make an all-out fight against any and all forms of NHI.

The NHI debates were THE issue at

the 1976 Clinical Convention, providing four hours of testimony before a reference committee and two hours of debate on the House floor.

The president of the American Medical Association strongly urged members not to "turn their backs" on the national health insurance (NHI) debates.

"If we are to offer nothing in the way of NHI legislation," Richard E. Palmer, M.D., told the delegates, "we run the terrible risk of getting clobbered with everything," referring to the mandatory, comprehensive Kennedy-Corman NHI bill. The final vote on the issue was nearly identical to the PSRO vote (185-57) taken in Chicago in 1974. Many of the same faces that opposed PSRO also opposed NHI. It would appear that the liberal-conservative ratio in the House has not changed in the past two years.

The AMA's Annual Convention in San Francisco was one of the most successful in recent years—a total of 15,399 people, including 6,601 physicians, registering for the scientific program and sessions of the House of Delegates.

Nashville, Tenn., urologist Tom Nesbitt, M.D. was chosen president-elect of the American Medical Association by acclamation of the House of Delegates in San Francisco.

The 54-year-old urologist has been speaker of the House for four years. He ran unopposed for the AMA's top office.

Former Vice Speaker William Y. Rial, M.D. was elected speaker of the house, also by acclamation. Dr. Rial, 58, is a family physician in Swarthmore, Pa.

The Indiana delegation introduced resolution 38 on "Confidentiality of Physician and Patient Data" which was minimally amended and adopted by the AMA House. The resolution asked that the AMA, through its proper committees and councils establish:

1. Ethical guidelines which define procedures for the management of a computerized patient data base.
2. Ethical guidelines which define procedures which control the access to clinical data and limit access to the computerized data base.
3. An accrediting agency for computer service bureaus to reassure patients that their information will not be misused.

The minor change was on item three, The AMA House changed the third word "agency" to "guidelines."

Considerable testimony in the reference committee and on the House floor was voiced by Indiana delegate George Lukemeyer, M.D., in disapproval of the AMA policy regarding HR2222 which classifies residents as hospital employees under the National Labor Relations Act with the capacity of negotiating for

wages and other benefits of institutional employment.

The AMA House, however, reaffirmed that housestaff are both students and employees and are entitled to bargaining rights under the National Labor Relations Act.

In a contentious discussion rivaled only by the debate over national health insurance, delegates approved a reference committee recommendation that this dual role is not mutually exclusive and does not detract from medical education.

In recommending continued support of this policy, the house backed the reference committee's statement about the "realities of the residency program."

Key issues discussed included national health insurance—or "comprehensive" health insurance, as delegates have now decided to call it—the Food and Drug Act, the Health Planning Act, the Health Professions Educational Assistance Act, and proposed ceiling on hospital costs.

Discussion of each included calls from the more conservative members of the House for all-out fights against the government. But delegates eventually decided that the best means of trying to solve the medical profession's problems with government is to support the previous stands taken by the House and the actions of the Board of Trustees in trying to implement those stands.

For the third straight session of the House, national health insurance was the main topic. The House reaffirmed its support of the AMA's proposal for national health insurance, instructed the board to assure that the proposal will not in any way lead to the "nationalization" of American medicine, and, finally, urged that the term "comprehensive," rather than "national," be used in describing AMA's health insurance proposal.

The case for retaining an AMA proposal on NHI was stated during reference committee hearings by Joe Boyle, M.D., an AMA trustee from California. Referring to the speech given earlier to AMA by HEW Secretary Joseph Califano, Dr. Boyle said, "We know the (Carter) Administration is out to get us; we just don't know how yet. We had better heed the warnings and keep AMA involved in the discussions."

With the deadline approaching for the implementation of Professional Standards Review Organizations, the American Medical Association House of Delegates acted in San Francisco to clarify AMA policy on PSRO.

Some physicians continued to resist what they considered the imposition of PSROs. Milton A. Kamsler, Jr., M.D., from San Mateo County, Calif., which rejected voluntary establishment of a PSRO, asked the AMA to urge a halt to the program and insist on an audit of PSROs.

The house subsequently adopted an amended resolution that encourages physician sponsorship of PSROs in areas currently without such an agency. The resolution also proposed criteria for physician participation in "alternate PSROs," those that might be imposed on areas.

General policy guidelines on the ethics of physicians testifying as "expert witnesses" in malpractice cases were approved by the House of Delegates in San Francisco.

AMA policy will now say that "expert witness" physicians should be professionally qualified, in the judgment of their peers, to provide the testimony sought in malpractice cases.

Further, the AMA expressed its concern over physicians who are hired as expert witnesses as part of their occupations, and condemned those who give "false or misleading" testimony or misrepresent their qualifications.

Hospitals and medical staffs should have adequate liability insurance, and should work out cooperation plans for handling suits, but choice of insurance coverage should remain the independent responsibility of each, the House of Delegates ruled.

The measure, approving a Board of Trustees report, was taken in place of a resolution from last year's Dallas convention that sought rules to be set up requiring minimum insurance levels and mandating cooperation in lawsuits.

The resolution had sought to avoid the sometimes bitter conflicts between hospitals and physicians when both are named defendants in malpractice suits.

There may be a full-time president in AMA's future, but nobody knows when, how or who.

Delegates debated whether the Association needs a full-time president, whether such a president should also be the chief executive officer, and whether the House or the Board should select such a president.

After hours of reference committee testimony and debate on the House floor, the issue was referred to the Board for further study, with the proviso that the House wants to continue to name the president of the AMA. A report is to be made at the 1977 interim meeting.

AMA dues will continue to be \$250 a year for regular members, \$35 for residents, and \$15 for medical students, for the time being, the House of Delegates decided.

Then AMA regular dues were more than doubled in 1975, the delegates ordered the Board of Trustees to review the dues level at each Annual Convention, with an eye toward reducing them when the AMA's financial status permitted it.

The Association is in much better financial shape now, according to the official auditor's report presented to the

House of Delegates, but the Board recommended that dues not be changed now.

Any doubts about the direction of the Carter Administration's health policy were dispelled during the AMA's annual convention in San Francisco.

First, Joseph Califano Jr., secretary of the U.S. Department of Health, Education, and Welfare, told AMA delegates, "National health insurance to protect all Americans from the crushing burden of medical expenses is essential."

The health care industry, Califano said, must be restructured, "to organize health resources more effectively, distribute health care benefits more equitably, emphasize prevention and primary care, and establish a fair and effective system of national health insurance."

Second, the HEW secretary's advisory committee on NHI held the first of its regional "road shows" immediately prior to Califano's address to the AMA, and it is apparent from the paces the 36 member committee is being put through that its final recommendations are meant to mirror the impressions Califano shared with the AMA.

Because current statutes and court opinions contain flimsy guidelines for physicians on the medical management of terminal illness, the American Medical Association's Judicial Council adopted a recommendation for a firm stand on the right-to-die issues.

Mercy killing or euthanasia is contrary to public policy, medical tradition and the "most fundamental measures of human values and worth," the council reported at the annual convention in San Francisco. This stand is an affirmation of previous AMA policy.

When there is irrefutable evidence that biological death is imminent, it is the patient's decision (or his family's) to request the withdrawal of extraordinary means to prolong his life, the council said.

The physician's opinion, however, should not be discounted, the council added. "The advice and judgment of the physicians involved should be readily available to the patient and his family," the report stated.

The House of Delegates urged the AMA to hire a physician part-time in the Association's Department of Negotiations, over the strong objection of the Board chairman and the executive vice president.

The Missouri delegation had introduced a measure calling for the AMA to hire a physician full-time in the negotiations department, but later modified it to part-time only, paid on a per diem basis.

Board Chairman Raymond T. Holden, M.D., voiced strong opposition to the resolution, saying that hiring of staff members should be entirely under the

control of Executive Vice President James H. Sammons, M.D. Such an action by the house would be disruptive to effective management of the AMA staff, he said.

The House modified the measure to say that the AMA "may" hire a part-time physician for the negotiations department, and passed it as amended.

Dr. Sammons, after the house action, warned strongly that House intrusion into staff policy would be detrimental to the AMA. He expalined that the resolution had been offered after the Missouri delegation had suggested an unnamed Missouri physician be hired on the staff. The physician in question would be considered, Dr. Sammons said, if the AMA decided that a physician was needed in the negotiations department.

Medicare continues to create problems for practicing physicians, one of the most frustrating of which is the federal release of physician reimbursement lists that are plagued with inaccuracies.

One of the several Medicare-Medicaid related resolutions and reports adopted by the AMA House of Delegates urged the officers and staff of the AMA to investigate all possible avenues, including legislative action, that might prevent the further release of such lists.

Laetrile is a substance that has no proven value as a drug, the American Medical Association House of Delegates said at its annual meeting in San Francisco.

The position statement came in the wake of action by nine state legislatures in the last two months legalizing the use and administration of the apricot extract, contradicting Food and Drug Administration policy. Several states have also approved the manufacture of the substance.

The new AMA position buttresses policy handed down by the House at last winter's Clinical Convention.

The public should be warned about "the danger in delay of diagnosis and treatment of malignancies by methods not generally recognized by the medical profession as beneficial and effective," the delegates said.

In addition, the delegates stated in 1976 that "the use of amygdalin (laetrile) exploits the victims of malignancies and their families by preying upon the emotions of the hopelessly ill, in some cases for the profit of the unscrupulous."

The American Medical Association will continue to oppose mandatory patient package inserts for all drugs approved for marketing by the Food and Drug Administration.

Physicians testifying during reference committee hearings at the Annual Convention said that the inserts might aggravate patient non-compliance as well

as instigate unnecessary alarm through misinterpretation of pharmaceutical companies' listed contraindications.

The major concern expressed by physicians during debate on a resolution that urged repeal of the Delaney Amendment (to the Food Additive Act) was that artificial dosages used for experimental purposes bear no relation to human consumption.

The AMA, in an amended resolution, supported passage of legislation that would change the Food Additive Act "to require evidence based on scientifically reproducible studies on the association of food additivies with an increased incidence of cancer in animals or humans at dosage levels related to amounts calculated as normal daily consumption for humans."

In some of the other activities the House of Delegates:

- Referred to the board for further consideration a resolution calling for the AMA to prepare policies and strategies to deal with strikes, lockouts, job actions, and other work stoppages that affect quality and availability of medical care.
- Endorsed the concept that the number of complete on-site hospital reviews be reduced to a minimum and that they be comprehensive enough to supply data to all legitimate agencies.
- Referred a resolution asking the AMA to develop and advocate proposals to permit hospitals to reclassify a patient's status in short-term hospitals, where surplus beds exist, to a "skilled nursing" level.
- Referred a resolution asking the AMA to notify members that attending physicians are not required or legally responsible for certifying and recertifying the need for hospital care for Medicare and Medicaid patients.
- Resolved that all AMA members adhere to the principle of due process, as specified by the AMA and JCAH, in any instance in which an AMA member passes judgment on any other member relating to professional ability, honor, or reputation.
- Supported the establishment of community programs for blood pressure monitoring as part of a national effort to combat hypertension.
- Supported general prison reform and the participation of prisoners in clinical studies of new drugs, provided prisoners are volunteers who have given informed consent.
- Urged inclusion of medical treatment for alcoholic and chemically dependent patients in federal employee health insurance.

- Recommended efforts to enact natural legislation to confirm the profession's authority to develop and use relative value studies.
- Urged that mass screenings of school children, particularly in fragmented organ system screening programs, be undertaken only with the approval of the local medical society.

The AMA must remain strong if it is to continue to be a counterweight to federal intervention, particularly on national health insurance, said AMA President John Budd, M.D.

In his inaugural address, Dr. Budd called the AMA 'a citadel for the survival of voluntary action, as opposed to the expanding power of centralized government."

Dr. Budd warned of the vicious circle of "a decline in the people's sense of power and the growth of federal power—unless groups like AMA resist."

A case in point, the AMA official said, is the government's effort to federalize medical care into a monolithic system. In making his point, Dr. Budd coined a new name for the AMA's proposal on NHI: "people's health insurance."

Delegates:
PATRICK J. V. CORCORAN, M.D.
PETER R. PETRICH, M.D.
JAMES A. HARSHMAN, M.D.
ROSS L. EGGER, M.D.
MALCOLM O. SCAMAHORN, M.D.

Alternate Delegates:
THOMAS C. TYRRELL, M.D.
MARVIN E. PRIDDY, M.D.
GOERGE T. LUKEMEYER, M.D.
GILBERT M. WILHELMUS, M.D.
EVERETT E. BICKERS, M.D.

Report of Chairman of the Board, James A. Harshman, M.D.

ACTION: Filed.

This year's report on the activities of the ISMA Board of Trustees is given in a little different format.

The Board has labored many days in implementing actions of previous House of Delegates' deliberations. Every effort has been made to fulfill the intent of last year's House actions. Rather than to enumerate the activities of the Board on previous House actions, you are referred to Board of Trustees Reports A through T.

In addition to the above actions, considerable attention was given to the future. Most importantly, additions have been made to our headquarters staff in order that we can respond to the future needs of our membership.

The Board identified several goals early in the year. One of our immediate needs was in the area of legislation, on both a state and national level. A legislative analyst, Mr. Rick King, was added to our staff. Our accomplishments in the past at the state level have been remarkably successful. With each succeeding year the intensity of legislative activity grows. As other groups have become more professional and effective in their legislative efforts, it has become necessary for ISMA to respond likewise. We have met this challenge.

For the first time, ISMA has responded to national legislation. The board has submitted written testimony to Congressional hearings on several key legislative issues. Noticeable results have already been realized in our efforts on the national scene. It will take a concerted and sustained effort for several years before our credibility in legislative analysis is established at the Washington scene. We anticipate continuously to respond to federal regulations as they are published.

In addition to responding to state and national legislation, it has become necessary for us to respond in an effective and responsible manner to other government documents. Responses were made to the Criteria, Standards, and Guidelines for Perinatal Health Services in Indiana and to the preliminary draft of the State Health Plan. We will continue to study, comment, and develop positions on reports, plans and rules and regulations of state and federal agencies, especially those that intrude into our practices and interfere with our ability to serve our patients.

Another goal of the Board was to establish some sort of mechanism to represent our membership on issues they will face collectively. It is apparent that organized medicine must develop a capability to negotiate for its members on issues we will face with third-party payers and governmental agencies. A Department of Negotiations is being considered to meet this challenge. A Board report addresses this subject.

To meet expanded membership needs, in both the area of services and in negotiations, it will be necessary for the Association to develop data-processing capabilities. A significant amount of front end financial assistance may be needed to develop these data processing services. The Board has made a major commitment to institute computer services at ISMA headquarters. At the present, our commitment is limited to computer services which will handle our financial management system and membership billing and record keeping system with an expanded physician data base. Consideration will also be given to providing data processing services in other areas. The Board seeks guidance from the House in this matter.

The Board has continued to closely monitor the malpractice situation in Indiana. Additional amendments have been made to P.L. 146. A countersuit program has been instituted. The Association has filed briefs supporting the constitutionality of P.L. 146 in connection with a malpractice case that will test its constitutionality.

The Board is deeply indebted to all of the ISMA commissions and committees and to ISMA staff which gave invaluable assistance and advice to us throughout the year. Without their dedication and assistance our task would have been impossible to carry out.

Finally, I would like to thank each trustee for his untiring efforts. It has made my charge as chairman a most memorable experience.

Report A

Subject: Unified Membership

ACTION: Filed.

This report is in response to a request from the House of Delegates to the Board of Trustees to report back in October of 1977 on the matter of Unified Membership.

At the present time there are only five states which have unified membership at all three levels—county, state and AMA. These states include: Arizona, Hawaii, Illinois, Oklahoma and Wisconsin.

It is interesting to note that in one of the states membership is approximately 91% of those eligible, whereas in the other four states membership ranges from approximately 63% to 82%.

The ISMA has as members approximately 82% of the total physician population in Indiana, not all of whom are eligible for membership. Of those physicians engaged in direct patient care about 93% are members of ISMA.

At the end of 1976 approximately 84% of ISMA members were also AMA members. Therefore, Indiana's level of membership in AMA is higher by comparison with all those states having unified membership except one.

A membership opinion poll was conducted during the latter part of 1976 and included the following question regarding unified membership:

To join the ISMA, you must first be a member of your county and district societies. When you join at the county and state levels you are then eligible to join AMA. Would you favor the ISMA becoming a completely unified state and requiring its members to maintain concurrent membership in the AMA?

There were 1,628 responses to this question. Some 479 responded affirmatively while, 1,149 (71%) responded NO, indicating they do not want unified membership. It is worth noting, also, that there is one county in the state which

has retained unified membership at all three levels.

Based on the results of the recent membership opinion poll, and because of ISMA's high level of AMA membership it is the opinion of the Board of Trustees that ISMA not adopt Unified Membership for Indiana. However, ISMA should continue to encourage all members to join AMA in order to insure a strong voice for organized medicine at the national level.

Report B

Subject: Tel-Med

ACTION: Adopted.

The Tel-Med program was shut down by the Board on June 6, 1977, due to a lack of outside funding available to carry it through the end of the fiscal year.

ISMA will continue to maintain the franchise for six months to determine if the county medical societies, or some other outside source, would be interested in using or taking over the program.

Blue Cross/Blue Shield has expressed an interest in cosponsoring the program with ISMA, but no formal discussion has taken place.

Indiana University also indicated some early interest in taking over the program but recently declined to pursue the matter further.

St. Joseph County Medical Society is the only county society that has expressed specific interest in the program. As a result, the Executive Committee recently approved lending the program's equipment and tapes to the St. Joseph County Medical Society.

Report C

Subject: Countersuit Program

ACTION: Adopted.

This report is in response to ISMA House of Delegates' Resolutions 76-3; 76-25 and 76-27. The Indiana State Medical Association House of Delegates is concerned about the proliferation of medical malpractice actions being filed in the state courts. In addition, to providing relief to the malpractice crisis by legislation many ISMA members believe a significant number of these actions are non-meritorious. Therefore, ISMA House of Delegates directed that a countersuit program be initiated.

The appropriate role that ISMA can serve is a review and research one to accomplish support of a plaintiff in his countersuit. Therefore ISMA's primary role will be as a research clearinghouse with volunteer physicians participating in an expert witness pool for the benefit of the Association member at the trial level.

ISMA cannot provide funds directly to support the physician's countersuit without jeopardizing the Association's not-for-profit status.

Briefly, four conditions must be met for a countersuit to receive serious consideration: the original malpractice suit must be settled in favor of the physician defendant; there must be malice on behalf of the plaintiff; there must be a lack of probable cause; there must be injury to the defendant.

The ISMA staff counsel would then need the following information to complete the initial review: copy of complaint and answer, medical documentation, progress notes, case history, interrogations, deposition, request for admissions, court orders, names of attorneys involved and information on all parties.

In implementing a review program at least the following tasks must be performed: accomplish whatever liaison correspondence remains necessary; legal counsel performs an initial review of the case; legal counsel contacts member and his counsel; legal research is conducted in applicable areas; alternative causes of action are identified; report of legal review is submitted to appropriate committee with recommendation as to the merit of the case and decision by the Board on assistance to be given; as authorized by the committee, assist physician and counsel with legal research, opinions, etc.; utilize resource pool of medical experts if necessary to advise committee and on appeal the ISMA could join as an amicus curiae.

The Indiana State Medical Association countersuit program has been in operation for the past five months. The ISMA staff has answered numerous questions concerning the program. At the present time, several cases have been approved by the Executive Committee for review by outside counsel.

Report D
Subject: Physician Assistants (HB 1427)

ACTION: Filed.

In response to Resolution 75-20, the Indiana State Medical Association resolved to support legislation which would authorize physicians to use appropriately trained supportive personnel under physician supervision. These persons would include graduates of physician assistant training programs certified by the State Medical Licensing Board. House Bill 1427, enacted in the 1977 General Assembly, recognized "physician assistant" as a distinct health care occupation.

The Medical Practice Act was amended to define the physician assistant and his duties. A physician assistant is defined as an employee of a physician who is a graduate of a physician assistant training program approved by the Board and who has successfully completed the national examination and registered with the Board.

The clinical duties which any physician employee or the physician assistant is delegated to perform for the employing

physician or group are acts which customarily come within the specific practice area of the employing physician. The employee may not make a diagnosis or prescribe a treatment and must report results of any examination to the supervising physician. Additionally, the physician assistant may not administer medication without a specific order. The statute further prohibits independent practice by a physician assistant.

The Commission on Medical Education was assigned the task, by the Board of Trustees, of reviewing the proposed rules and regulations implementing the intent of HB 1427 which modifies the Medical Practice Act. The Commission has conveyed its comments to the Medical Licensing Board and made staff available for further assistance.

Report E
Subject: Definition of Death (HB 1433)

ACTION: Referred to Commission on Legislation for continued action.

Resolution 76-29 directed that legislation be introduced which defined death as follows:

'Death' means that a person will be considered dead if in the announced opinion of an attending physician, based on ordinary standards of medical practice, the patient has experienced an irreversible cessation of spontaneous respiratory and circulatory functions; or, in the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice, the patient has experienced an irreversible cessation of spontaneous brain functions.

House Bill 1433 was introduced by Representative E. Henry Lamkin, M.D., incorporating the above language. The legislation passed the House of Representatives on a close vote, but was not considered by the Senate Health Committee.

The opponents of this legislation exploited the confusion created by the Right to Die bill, which ISMA opposed, to defeat the definition of death legislation.

Report F
Subject: Peer Review Immunity (HB 1664)

ACTION: Filed.

In response to House of Delegates Resolutions 76-18 and 76-23 calling for immunity from suit when performing peer review activity, the ISMA successfully supported House Bill 1664. This legislation provides immunity for health care providers who organize voluntarily, or under state and federal enabling sta-

tutes to conduct peer review. A review committee may consider the patient care rendered by the health care provider as well as the qualifications of a health care provider with complete immunity. This evaluation relates only to accuracy of diagnosis, propriety of therapy and reasonableness of utilization of service, procedure and facilities. Such activity may be either pre-admission, concurrent or post-admission review.

Report G
Subject: Generic Substitution of a Prescribed Drug (HB 1050/HB 2076)

ACTION: Referred to the Board for continued action.

This report is in response to House of Delegates Resolution 76-1 which directed ISMA to oppose generic substitution of a prescribed drug done at the discretion of a pharmacist and to make ISMA policy known to the Indiana General Assembly.

Two bills introduced to allow for generic substitution were assigned to committee, but neither received a hearing in the House. The various drug manufacturers and ISMA opposed this legislation. The previous strong opposition to the bill and the lack of organized strength of the proponents should relegate this issue to the background in the next legislative session. However, the elections for the 1979 General Assembly and afterwards may be the targeted sessions for a strong push by the proponents of generic substitution for the passage of legislation. The Board will continue to monitor this situation.

Report H
Subject: Surveillance of HSAs

ACTION: Adopted.

Although Resolution 76-11 (ISMA Representative to Health Systems Agencies) was not adopted by the House of Delegates, the Board of Trustees agreed that there was an immediate need to accomplish the above.

Therefore, your ISMA has held periodic meetings for physicians serving on HSA Boards and sub area advisory councils. The Association has deployed a third field representative after realigning its field service operations along the lines of the three Health Service areas in order to bolster efforts to more adequately exercise surveillance of the HSAs, and to communicate and coordinate this information with your ISMA, County Medical Society, and physician participants on the HSA Boards.

Your ISMA is serving as an information clearinghouse on HSAs and disseminating pertinent information and materials among all those physicians serving on HSA Boards and sub area advisory councils. The ISMA field staff plans to meet periodically with staff of the Indi-

ana Hospital Association covering HSAs to exchange information. It is hoped that the association will soon be capable of reviewing significant HSA materials and providing comments in order to facilitate physician participation and input.

Report I

Subject: Scoliosis Screening

ACTION: Filed. (Further reference: Resolution 77-16)

Resolution 76-2 asked that a scoliosis screening program be initiated by the Indiana State Medical Association and the resolution was referred by the Board to the Commission on Medical Services.

The Commission on Medical Services reviewed the resolution and recommended that contacts be made with appropriate persons and organizations requesting that the Indiana State Medical Association be provided with guidelines for screening for scoliosis. The guidelines would in turn be transmitted to county medical societies for their information in instituting such screening programs.

The materials were subsequently gathered by the Commission and referred to the Commission on Public Relations for finalization and distribution to the county societies.

The Commission on Public Relations discussed in detail the scoliosis screening program which had been utilized by the Vanderburgh County Medical Society and agreed that the information should be provided to county medical societies, requesting them to establish similar programs in cooperation with local school systems. The Commission on Public Relations also directed that a small article be included in *The Journal* reminding physicians to check for scoliosis in children.

Report J

Subject: Restriction on ISMA Insurance Coverage

ACTION: Filed.

Resolution 75-19 asked in its resolves that insurance companies providing group policies exclusively for ISMA members and their families be asked to provide coverage only to physicians who are current members of ISMA and further resolved that the AMA delegation recommend a similar action for group policies sold to AMA members.

The field staff was instructed to contact, personally, those physicians who had not paid dues to the ISMA and who were still being covered by ISMA policies, to so advise them of the resolution's intent and to encourage them to retain their memberships and not lose their insurance coverage.

Additionally, letters were transmitted to these delinquent members reminding them that they would lose their insurance benefits, should they not retain

membership in the ISMA.

The Indiana delegation to the American Medical Association introduced a similar resolution to the American Medical Association House of Delegates at its December 1976 meeting in Philadelphia. The resolution asked for discontinuance of group insurance programs for any physician not a member of the AMA. This resolution also requested that husbands and wives of deceased physicians be allowed to continue their insurance coverage under AMA group policies and this resolution passed the AMA House, and is being currently implemented.

Report K

Subject: CHAMPUS

ACTION: Adopted.

Early in 1977 the CHAMPUS Division of the Indiana State Medical Association ceased operations and the contract for administration of the program in Indiana and Kentucky was given to Professional Research Corporation.

In April the Professional Research Corporation through an agent company, AVATAR, presented to the ISMA a proposal which requested the Indiana State Medical Association to provide peer review on questionable claims.

The proposal was reviewed by both the Commission on Medical Services and the Board Committee on Medical Services and both bodies recommended to the Board that the proposal be rejected. The Board of Trustees, subsequently, adopted the recommendation of both Committee and Commission.

In July the Association was advised by CHAMPUS that the Professional Research Corporation requested release from its contract to process CHAMPUS claims in Indiana and Kentucky. Wisconsin Physicians' Service (Blue Shield) was recently selected as the interim contractor. It is anticipated that the contract will be open to competitive bids again next year.

Report L

Subject: Billing Procedure under Medicaid

ACTION: Adopted.

Resolution 76-14 resolved that the Indiana State Medical Association take appropriate steps in cooperation with the Indiana Department of Public Welfare and the Medicaid fiscal intermediary to develop a simplified billing procedure.

Introduced by the Commission on Medical Services in 1976 the matter was referred back to the Commission for implementation.

To carry out the resolution's intent the Commission on Medical Services has met several times with Mr. Wayne Stanton, Administrator, Indiana Department

of Public Welfare, and members of his staff.

Mr. Stanton has appeared to be receptive to such meetings. Therefore, the Commission on Medical Services will continue meeting with Mr. Stanton in order to foster liaison with his office and to accomplish solutions to fees, billing procedures and other areas of concern in the delivery of medical services under the Medicaid Program.

Full reports of these accomplishments are included in the Commission's annual report to the House of Delegates, which will be followed by a supplementary report to the House.

Report M

Subject: Negotiations

ACTION: Filed (Further reference: Resolution 77-47; Report of Ad Hoc Committee on Arbitration)

ISMA resolutions 76-4, 76-6, 76-10 dealt with ISMA functioning as a collective bargaining agent, fee mediation with insurance and patient physician contacts.

Amended substitute resolution 76-4 was adopted by the ISMA House of Delegates and dealt with the current structure of medical care financing. The resolution cited suggested systems for providing such equitable treatment with the following options a) statewide collective bargaining, b) formation of a state medical foundation for medical care, c) ISMA acting as a party to insurance negotiations, d) adoption of insurance payment plans in substitution for "usual and customary . . ."

The resolution asked that the Board of Trustees and the appropriate committees and commissions of the ISMA study these and other alternatives and prepare a report for resubmission to the House of Delegates in 1977.

The President of ISMA appointed an Ad Hoc Committee on Arbitration to carry out the mandate of the House. A detailed report from this committee will be before the House of Delegates in October 1977.

The report emphasizes the need for studying the subject of negotiations more thoroughly and points out the extensive training seminars being conducted throughout the country by the AMA Department of Negotiations. The report also recommends that a permanent Committee on Negotiations be established by the ISMA.

At its July meeting the Board of Trustees was exposed to the basic seminar on negotiations conducted by the AMA Department of Negotiations.

Report N

Subject: Board Communication to Membership

ACTION: Filed.

In order to facilitate timely communications to the membership regarding significant Board of Trustees actions, the Chairman of the Board now disseminates "ISMA Board Actions" following each Board meeting.

This is being done in partial response to resolution 76-20, which requested that each trustee be encouraged to submit at least two communications, but not more than four per year to the ISMA for distribution to his individual district members, thus resulting in needed communications.

Judging from membership reaction, this new report fills the communication gap reflected in Resolution 76-20 and has been very well received.

Report O

Subject: Continuing Medical Education

ACTION: Adopted.

President Vincent J. Santare, M.D., in his address at the 1976 ISMA Annual Meeting, commented on CME as follows:

In the aspect of demands by the government or consumer groups for relicensure, a suggestion by this Commission has been for continuing medical education to be a requisite for membership in the ISMA. CME, in the fashion of the Physician's Recognition Award, is already mandated by the Academy of Family Practice. It will be a requirement of all the specialty boards and is being implemented in the specialty societies. At one time I thought that CME, on a trial basis, should be made a requirement for an elite state medical association. However, on careful consideration of the amount of effort, cost and involvement in such a program. I cannot feel that the value is worth the expenditure. Most doctors will continue postgraduate training in education without the goal of relicensure or requirement for state medical association membership. Inasmuch as specialty organizations are now requiring continuing medical education, perhaps it would be superfluous for us to do so in our state medical organization.

Based on Dr. Santare's remarks and referral to the Commission on Medical Education for development of a voluntary statewide coordinated Medical Education Program for the State of Indiana, the Commission made the following recommendation to the Board of Trustees:

That CME be made a voluntary requirement for ISMA membership for an initial three (3) year period. After that time CME at the rate of fifty (50) hours per year or one hundred fifty (150) hours over a three (3) year period become mandatory for ISMA membership.

On June 12, 1977, Steven C. Beering, M.D., chairman of the ISMA Commis-

sion on Medical Education appeared before the Board of Trustees to discuss, among other subjects, the commission's recommendation.

Following discussion, the Board of Trustees took the following action:

That ISMA continue to encourage CME on a voluntary basis and voice its objection to CME being made a requirement for membership in ISMA as well as CME being made mandatory for relicensure and re-registration.

Report P

Subject: Membership Opinion Poll

ACTION: Filed.

The Future Planning Committee, in an attempt to determine how ISMA could better serve its members, constructed a membership opinion poll which was approved by the Board of Trustees.

The poll was considered very successful and provided ISMA members an opportunity to present their views to the Board of Trustees.

One of the immediate results of the poll was the discontinuation of the Tel-Med program by the Board of Trustees. The Committee reported to the Board that statistics in the survey indicated that a minimal number of physicians use and/or support Tel-Med. This fact, coupled with the lack of funds to continue the program, were the major reasons for the Board's action.

Other recommendation from the Future Planning Committee, resulting from the membership opinion poll, will be divided into sections and referred to committees and commission where appropriate for further study and action.

The results of the 42 questions included in the questionnaire were based on responses from 1,712 physicians. On the basis of these responses, the Future Planning Committee made the following recommendations:

- 1) That AMA membership not be mandatory;
- 2) That the types of insurance coverage cited in the questionnaire be further investigated;
- 3) That physicians be encouraged to participate in continuing medical education;
- 4) That the possibility of offering the membership the opportunity to purchase the items indicated in the questionnaire be considered;
- 5) That the Editorial Board consider a revised format for *The Journal*;
- 6) That the News Flash be continued in its present form;
- 7) That Tel-Med become financially self-supporting;
- 8) That a modest registration fee be charged members at the ISMA annual convention;
- 9) That efforts being made to improve

public representation of ISMA be continued;

- 10) That ISMA proceed to develop programs in the area of practice management and consultative services.

The Board of Trustees commended the Future Planning Committee for its time-consuming efforts and a job well done.

Report Q

Subject: Sports Medicine

ACTION: Adopted.

During the year, the Commission on Medical Services received a report from the Subcommittee on Sports and Medicine on a proposed program which would provide greater availability of athletic trainers to the secondary school system of Indiana.

Presentation to the Committee was made by Mr. Pinky Newell, athletic trainer at Purdue University, and Mr. Richard Hoover, in the private practice of physical therapy. They presented a proposal directed toward the planning, organization and implementation of a comprehensive and viable sports medicine program for the state of Indiana.

An explanation of the program was presented to the Board of Trustees at the July 28, 1977, meeting of the Board with a recommendation from the Commission on Medical Services that:

1. The Sports Medicine Program be endorsed by the Indiana State Medical Association;
2. That a pilot program on the project be assisted in every way by ISMA to insure its success;
3. That the program be named the Indiana Medical Association Sports Medicine Program;
4. That consideration be given to providing necessary office space in the Association's property at 3942 North Pennsylvania Street.

The Board of Trustees deferred taking any action with respect to the program until its September meeting, pending delineation by the Subcommittee on Sports and Medicine of the specific actions to be requested of the Board.

The Subcommittee on Sports and Medicine presented a report to the Board of Trustees at the Sept. 11, 1977, meeting of the Board. The report detailed a budget and plan for inaugurating the Sports Medicine Program in 1978 and requested a sum of four thousand dollars (\$4,000.00).

With the understanding that this allocation would be granted on a one-time basis and that the Indiana Sports Medicine Program would be self-supporting in subsequent years, the Board approved the budget.

Report R

Subject: Certificate of Need (HB 1418)

ACTION: Referred to the Commission on Legislation for continued opposition.

Certificate of Need legislation was introduced into the House Public Health Committee chaired by Representative Dan Huff. The legislation included all capital expenditures in excess of \$100,000 and would have, therefore, included physicians' offices. Public hearings were conducted with Indiana State Board of Health, Indiana Hospital Association, and ISMA testifying. The State Board of Health urged passage of the legislation but requested the deletion of physicians' offices from the bill. The Indiana Hospital Association urged adoption of the statute in its original form. ISMA testified in opposition to the legislation, and the bill was not brought to a vote in committee.

It appears that considerable pressure is being brought to bear upon the State Health Planning and Development Agency (State Board of Health) to develop some form of certificate of need program to be in compliance with the provisions of PL 93-641. According to federal regulations, if some type of legislation granting statutory administrative authority to the SHPDA (State Board of Health), consistent with the requirements of PL 93-641, is not in effect prior to July 1, 1978, the State Agency could lose its designation and another agency may be selected by HEW.

Report S

Subject: Update of Computer Development Activities

ACTION: Filed. (Further reference: Resolutions 77-33, 77-48, and Report of the Commission on Medical Services)

During the past year the Board of Trustees approved a recommendation from the Future Planning Committee that the Association conduct a feasibility study on computer applications. The firm of Medical Marketing Services of Chicago was awarded the contract to undertake the study. Its report was completed in January, 1977, and submitted to the Board of Trustees for consideration.

The study report cited a number of record-keeping deficiencies in ISMA's existing membership system as well as many opportunities for improving and expanding ISMA services with an internal computer capability. The overall conclusion of the study was that it is indeed feasible for ISMA to develop its own computer capability. With this capability, according to the study report, the ISMA could become the principal repository and source of all significant physician and perhaps patient-related data thereby emerging as the main interface between the physician and third parties. A physician-controlled data system would help to

ensure the prudent dissemination of data and preserve its confidentiality. Any expansion into patient related data will be contingent upon the acquisition of additional information on specific data requirements in order to facilitate system design and subsequent direction from the House of Delegates. Such an undertaking would undoubtedly require a significant financial outlay.

Although the Board accepted the study's findings in principle, it did not adopt the report in toto. Nevertheless the Board did approve the following:

(1) The development of an expanded Indiana physician data base to facilitate the design of a new internal computerized membership system that will serve as a replacement for the present AMA-sponsored AM-CAP system to which ISMA currently subscribes;

(2) The development of an internal financial management system to replace the one ISMA currently subscribes to from Data Control of Chicago;

(3) The appointment of a Physician Data Base Management Committee to define the specific items of information to be included in an expanded physician data base;

(4) The appointment of a Patient Data Management Advisory Committee.

The tasks confronting each of these committees are formidable. However, the problems facing organized medicine threaten its very fabric and medicine must be ready to meet the challenge. The cliché that "he who controls the data, controls" has a great deal of practical application to medicine's predicament. It may not be too late for ISMA to assert itself in this arena if it moves quickly and decisively.

The design of a new ISMA membership system is under way, predicated on an internal computer capability. In this connection, a letter of intent has been submitted to IBM requesting delivery of an IBM System 32 Computer for delivery in January 1978. The Physician Data Base Committee has already met and will oversee development.

A letter of proposal has been submitted that would have ISMA provide computerized services to the Indiana Medical Licensing Board along the same lines as would any commercial computer service bureau. Such an interface with the Medical Licensing Board would achieve the objective of making ISMA the principal repository of all physician data, thereby enhancing ISMA's membership system and physician master file. This proposal will be considered by the Medical Licensing Board at its September 15th meeting.

Finally, the Indiana State Board of Health contacted ISMA regarding the collection, under an agreement, of certain kinds of health services data to facilitate the work of its technical advisory committees. These committees are

charged with responsibility for developing criteria and standards for the delivery of various types of health services in Indiana. ISMA's participation in the project will guarantee the release of summary statistical data, thus maintaining confidentiality. A contract proposal providing for the above is presently being negotiated and will be presented to the Executive Committee for final approval.

Report T

Subject: Catastrophic Insurance

ACTION: Filed.

Resolution 76-24 dealing with the subject of catastrophic insurance resolved that the Indiana State Medical Association Board of Trustees urges labor and management, government and all persons to obtain catastrophic insurance under the current insurance policies—to protect from financial stress of catastrophic illness, and further resolved that the Board be instructed to work for the development of such a program of catastrophic insurance in the private sector which would be available to all the citizens of the state of Indiana and take the lead for publicizing this program and assuring coverage of all citizens in Indiana.

This resolution has been referred by the Board of Trustees to both the Commission on Medical Services and the Board Committee on Medical Services. Efforts have been made by both the Committee and Commission to obtain information in depth on the experience in Connecticut and Arizona. No information was forthcoming from Connecticut, and Arizona advised that when and if a statewide program for catastrophic coverage was developed for its citizens they would provide details of the plan to the Indiana State Medical Association.

In early December 1976, James Harshman, M.D. wrote to Joseph Black, M.D., chairman of the Blue Shield Board, reaffirming that he (Dr. Harshman) had learned at the Philadelphia meeting of the AMA that Blue Shield was "actively studying the feasibility of offering a free standing catastrophic insurance policy."

In February Dr. Harshman was advised by Blue Shield that formal recommendation on such a plan was anticipated by June 30, 1977.

ISMA officials and staff have continued communication with Blue Cross/Blue Shield on this matter and, as of Sept. 1, 1977, had received no information as to the actual progress of the study or projected plan.

Additionally, the Health Insurance Association of America (HIAA) met with the Executive Committee in Chicago on Jan. 7, 1977, and subsequently provided ISMA with information indicating that "95% of Indiana's population under age

65 have some form of catastrophic coverage in the amount of \$10,000 or more."

In a letter dated May 20, 1977, to Mr. Ken Bush from Mr. Woodrow E. Eno, HIAA legal counsel, it was stated "We were expecting to see a number of bills dealing with state health insurance plans and have been very surprised by the absence of such bills. This is not to say that there have been no bills at all introduced, but rather to suggest that a very limited number of bills have been introduced in the various states, and of those that have been introduced, few or none seem to have been aggressively considered by the various state legislatures."

He goes on to say that "The general public, legislators and state chief executive officers seem to have drawn the proper conclusion that such programs often come with very expensive price tags." Further, he adds that the legislators and people in general have begun to draw the conclusion that the catastrophic benefits are readily available in the current voluntary health insurance market."

In the Source Book of HIAA for 1976-1977 it is reported that nearly 144 million persons (3 out of 4 Americans under the age of 65) were protected by some form of catastrophic insurance in 1975.

JAMES A. HARSHMAN, M.D.
Chairman

Reports of Committees

Future Planning

ACTION: Filed.

The Future Planning Committee held five meetings this year on the following dates: Dec. 15, 1976; Jan. 19, 1977; Feb. 23, 1977; March 13, 1977, and May 11, 1977, all at the Association headquarters.

Following through with the program outlined last year, the Future Planning Committee approved a proposed protocol for conducting a feasibility study of potential computer applications. The following objectives were to be accomplished in Phase I of the study:

1. Analysis of technical and economic data processing requirements to support current and expanded specifications for membership record processing and accounting systems. This included the current AM-CAP system and the alternatives for in-house data processing capability.
2. Identification of new services that ISMA could make available to members as a result of having its own computer capability. These include:

- a) Membership dues billing and recordkeeping
- b) Reminder notices to delinquents
- c) Generation of special letters
- d) Printing of address labels for all mailings, including *The Journal*
- e) Bookkeeping, including monthly printouts
- f) Recordkeeping for continuing medical education
- g) Patient billing systems.
- h) Medical office bookkeeping systems
- i) Assistance to county society business bureaus

The objectives of Phase II of the study were considered long-range in nature and included:

- a) Provide technical assistance to ISMA leadership to assist in developing and implementing a long-range planning methodology for future information processing needs and desires.
- b) Definition of the parameters of a system that could enable ISMA to make data services available to government agencies, PSROs, HSAs, etc. This would include identification of specific participants in an ISMA medical data base.
- c) Development of a pro forma statement of income and expenses related to the implementation of such a program.

This plan was presented to the Board of Trustees on Aug. 29, 1976 and approved. The protocol was sent to a number of computer firms for an estimate. Membership Information Services for M.M.S., Inc., of Chicago received the contract to do the study, which was initiated on Oct. 22, 1976. When completed, the feasibility study included a summary of a report for Phase I, and also for Phase II.

The report indicated that the development of an internal computer capability by ISMA is logically sound and economically feasible. It can assist ISMA in the satisfaction of the following goals:

- 1) Improvement of internal ISMA operations
- 2) Establishment of ISMA as the medical data administrator for Indiana
- 3) Discovery of new sources of revenue
- 4) Provision of new benefits of ISMA membership.

It can guarantee ISMA's position of authority in Indiana health care, and protect the right of the physician to control the policies of medicine. When presented to the Board of Trustees of the Indiana State Medical Association, the development of a physician data base was approved. The Board also recommended the formation of three committees, physician data base, patient data

base, and a computer committee to followup further on the feasibility study recommendations.

The undertaking of a membership opinion poll was also approved by the Board of Trustees this past year. A poll was developed, printed and ready for distribution in time for the annual meeting in October 1976. There were one thousand seven hundred twelve (1,712) responses to the questionnaire. On the basis of these responses the committee recommended:

- 1) That AMA membership not be mandatory
- 2) Investigate offering the types of insurance coverage designated in the questionnaire
- 3) Encourage physicians to participate in continuing medical education
- 4) Investigate the possibility of offering the membership the equipment at special prices, as indicated in the questionnaire
- 5) The Editorial Board consider a revised format for *The Journal*
- 6) The News Flash be continued in its present format
- 7) Tel-Med become financially self-supporting
- 8) A modest registration fee be charged for the ISMA annual convention
- 9) Continue efforts being made in public representation
- 10) Proceed to develop programs in the areas of practice management and consultative services.

The membership poll was very successful in that it allowed ISMA members to present to the Board of Trustees their thoughts. On the basis of this poll, the Board of Trustees has discontinued Tel-Med with a savings to the membership of approximately sixty-seven thousand dollars (\$67,000.00) annually.

If the ISMA is to remain a major and viable spokesman for all physicians in Indiana, it is in definite need of some form of a physician and probably patient data bank. The Board of Trustees of the Indiana State Medical Association would also like to develop a system for obtaining the ideas and feelings of Indiana physicians rapidly and accurately in order to facilitate knowledgeable decision making.

The Future Planning Committee of the Indiana State Medical Association recommends that the Board of Trustees continue to pursue the concepts embraced in the computer feasibility study.

STANLEY CHERNISH, M.D.
Chairman

PETER R. PETRICH, M.D.; E. HENRY LAMKIN, JR., M.D.; JACK SHANKLIN, M.D.; FRED W. DAHLING, M.D.; RANDY LEE, M.D. (resident); WALTER HUNTER (student).

Grievance

ACTION: Adopted.

The Grievance Committee has met twice—April 16, and June 11, 1977. At the April meeting four new cases were reviewed and appropriate action taken. Four old cases were filed and six other miscellaneous cases were reviewed as to further disposition.

On June 11 the committee reviewed five new cases, filed five old cases and five other miscellaneous cases were discussed as to further disposition.

There will be at least one further meeting of the Grievance Committee before our October state meeting.

The chairman would like to offer to the membership the consensus of this committee:

"Most of our problems are in the area of patient-doctor communications. If we all could take a few extra minutes to try and truly communicate with our patients and their families, most of the complaints we receive would not happen."

We would like to offer our thanks to Kenneth W. Bush and especially to Elsie Reid for assistance to this committee.

Supplemental Report of the Grievance Committee

ACTION: Adopted.

Early in the year the President of the Association recommended to the Board of Trustees that changes be made to facilitate more effective and timely handling of grievances.

The Grievance Committee, during one of its regularly scheduled meetings, discussed, in detail, the five points presented by the President and agreed with his recommendations for streamlining the procedure. The committee expressed the opinion unanimously, however, that before any action was taken to implement proceedings on a grievance that the first step should be to contact the patient for his permission to send the complaint directly to the physician involved. This policy is currently included in the Grievance Committee Procedural Document.

Subsequently the Board of Trustees discussed the Grievance Committee operation of the Marion County Medical Society, and although no formal action was taken, the entire packet of materials, including sample letters and forms, were sent to members of the Grievance Committee for their consideration in the possible revision of the ISMA Grievance Committee Procedural Manual.

G. BEACH GATTMAN, M.D.,
Chairman

GEORGE T. LUKEMEYER, M.D.;
WILLIAM G. BANNON, M.D.; MARTIN J. O'NEILL, M.D.; ROBERT J. MARVEL, M.D.

Executive Committee

ACTION: Filed.

The Executive Committee met 12 times during the year to transact the business of the Association.

The committee, generally, dealt with the operation of the Headquarters office, clarified many policies on internal operation and maintained continuous surveillance over expenditures. Some of the issues and actions of the committee are enumerated below:

1. Revised the employee pension plan to conform with the Employees' Retirement Security Act of 1974 (ERISA).
2. As a result of vandalism in the Headquarters Office (an increasingly recurrent problem), the Executive Committee authorized the removal of all securities to the bank, the purchase of a fireproof vault for storing important ISMA records and the installation of a new security system.
3. Reviewed and approved or disapproved numerous requests for the ISMA mailing list.
4. Planned and participated in the annual visitation with Indiana congressmen in Washington, D.C., and explored the advisability of increasing these trips to maintain closer liaison with Indiana's representatives.
5. In conjunction with the Board of Trustees, authorized the staff to proceed with arrangements for a charter to the American Medical Association convention in San Francisco, which proved extremely successful.
6. Working in conjunction with the Indiana Hospital Association, the Executive Committee planned and participated in a program that focused on increasing government regulation.
7. Received several requests from county medical societies for National Health Service Corps physician assignees and referred them to the appropriate trustees for recommendations, all of which later received positive action.
8. Reviewed a request from IMPAC for a full-time PAC representative and referred the matter to the Board of Trustees which approved the request and assisted in the financial support of the representative who is currently working under the supervision of the Executive Director.
9. Referred to the Committee on Medical Services a request from the Professional Research Corporation for ISMA to review medical claims under the CHAMPUS program. The request was rejected by the Board of Trustees on recommendation of the Commission on Medical Services and the Committee of the Board of Trustees on Medical Services.
10. Approved the transmittal of a letter to President Carter criticizing the Swine Flu Immunization Program and

cautioning against adoption of a National Immunization Program.

11. Approved financial support for the partial sponsorship of student delegates to the American Medical Student Association.

12. Interceded on behalf of members with complaints involving relations with such groups as the Indiana Licensing Board, Medicaid, Medicare, private insurance carriers, etc.

13. Approved, following several revisions, a new ISMA Personnel Policies and Practices Manual.

14. Authorized the phasing out of the Tel-Med program.

15. Recommended that the Executive Committee be designated the authority to study the merits and approve late resolutions to the AMA where there is a submission deadline involved. (The usual procedure has been for the Board of Trustees to give final action) The Executive Committee would act in the event there would need to be decisions following the meeting of the Board of Trustees, usually held immediately prior to the AMA Convention.

16. Authorized transmission of a letter to the Governor stating ISMA's opposition to compulsory Continuing Medical Education and the bypassing of the legislative process by the Medical Licensing Board.

17. Approved an expenditure of \$4,000.00 for the preparation of a brief supporting the constitutionality of P.L. 146 for submission in a test case.

18. Authorized the hiring of an additional field representative. The three representatives are responsible in counties coinciding with the three Health Service Agency regions.

19. Notified all members of the opportunity to either redeem their loans to the building fund or contribute the amount to the building fund.

20. Sent comments, over the signature of the ISMA president, on the proposed Indiana Health Plan developed by the Indiana Health Planning and Development Agency.

21. Developed the annual budget for presentation to the Board of Trustees and hence to the House of Delegates.

We hope that the above enumeration of some of the actions will give the House of Delegates a quick sketch of the variety of issues and problems which came before the Committee.

The records of the Executive Committee are, of course, open to any member of the Association who would like to review them.

JOE DUKES, M.D.,
Chairman

ARVINE POPPLEWELL, M.D.,
RICHARD INGRAM, M.D., JOHN W. BEELER, M.D., ELI GOODMAN, M.D., JAMES A. HARSHMAN, M.D., VINCENT J. SANTARE, M.D., JOSEPH F. FERRARA, M.D.

Ad Hoc Committee on Computerized Axial Tomography Scanners

ACTION: Filed.

This Ad Hoc Committee was formed at the request of the President due to numerous problems which developed after introduction of computed tomography units into the state of Indiana. The high cost of such equipment generated much concern by the press and insurance carriers as it relates to individual exam charges and diagnostic value of scan procedures. Projected volume, criteria for justification of purchase of such units, as well as reasons for performing such exams were questions that are slowly being solved nationwide. Reimbursement and methods of determining such payment for head and body scans has created numerous concerns by physicians and hospitals. A Blue Cross Association CAT study calls for limits on physicians fees and restrictions on the placement of CAT equipment. Several studies on a statewide basis prepared by the Indiana State Board of Health and Health Systems Agencies, and supported by the Indiana Regional Medical Program and Blue Cross has produced similar documents. The ISMA has had no official representative involved in such projects.

This Committee has met by telephone and at the Indiana Roentgen Society Spring Meeting to discuss these problems. Body scanning has subsequently been recognized by Blue Cross as a procedure deemed worthy of payment, although federal programs have still determined it to be an investigative study.

The Committee is of the opinion that many of the early CAT problems have been corrected or eliminated. We are deeply concerned about the development of major health care decisions by insurance carriers and state and federal agencies. Such policies are made without the knowledge or invitation of official ISMA representation. This Committee recommends that the ISMA insist on either participating in such determinations or taking direct legal action to countermand any offensive ruling.

DONALD CHAMBERLAIN, M.D.
Chairman

L. RAY STEWART, M.D.; ROSCOE E. MILLER, M.D.; RAYMOND W. GIZE, M.D.; DAVID B. GOLDENBERG, M.D.; DAVID E. WHEELER, M.D.; JOHN E. JOYNER, M.D.; EVART MALCOLM BECK, M.D.

Ad Hoc Committee on Arbitration

ACTION: Filed. (Further reference: Resolution 77-47; Board of Trustees' Report M, Negotiations)

The Ad Hoc Committee on Arbitration and Negotiation met three times during the year. In addition, much study was done by telephone and mail. The committee members also attended the ISMA-AMA Negotiations Seminar in July.

The practice of medicine today is being overwhelmed by insurance carriers, consumer groups, labor unions and federal and state government agencies. Physicians have never before faced such problems from non-medical third party involvement. Demands from unionized hospital employees will ultimately result in hospitals being forced to restrict services. Third party payers arbitrarily set reimbursement schedules and government agencies arbitrarily establish many unnecessary and restrictive controls. We CAN and we MUST begin to influence these organizations in their actions.

Early in our study, it was readily apparent that, due to labor laws and current FTC rulings, the ISMA could not act as a collective bargaining agent in binding arbitration. The ISMA can, however, collectively negotiate in behalf of members, component societies and specialty societies. As we see it, the private practice of medicine as we know it and want it can survive only with the assistance of skillful negotiations, combined with the application of appropriate economic pressure. We must be prepared to act instead of react to proposals which affect the practice of medicine. Each physician cannot negotiate alone. We must have an organization with the advantage of collective power to assist us. Although it is unclear if the FTC will allow negotiating for payment schedules, most other problem areas are open for negotiations. As a matter of fact, Michigan State Medical Society has a negotiating committee which recently entered into successful negotiation with Blue Shield to effect a change in claim filing forms.

As you know, the AMA has established a Department of Negotiations. Through this department, the AMA is conducting training seminars in the art of negotiating for physicians and executives of component societies. The AMA will also assist members in component organizations in the resolution of their particular problem. This will be done by giving advice and even by appearance of department experts as spokesmen at the negotiating table.

Your committee feels that our Association must study this area more thoroughly. It is equally imperative, however, that we get our feet wet by implementing a program to train our own people in the art of negotiating and begin putting it to use. We, therefore, are recommending that the ISMA establish a permanent Committee on Negotiating. We feel that this committee should be

limited to possibly six to ten members. Membership should be for a period of six years and should be staggered to provide continuity of training and services. We would expect that this committee could eventually provide our own component societies, specialty societies and individual members with services similar to those of the AMA's Department of Negotiations. This committee should take full advantage of all programs of training and assistance offered by the AMA Department of negotiations. Areas in which the committee could be involved, but not limited to, are third party payers, governmental agencies and labor unions.

We feel that implementation of these recommendations will make ISMA better prepared to serve its members in preserving their professional and economic freedom.

It has been a pleasure to serve the ISMA on this committee and I would like to thank the members who diligently gave their time and effort in this project.

R. WYATT WEAVER, M.D.
Chairman

ROGER ROBISON, MD.; CHARLES HAMILTON, M.D.; HERBERT KHALOUF, M.D.

Ad Hoc Committee on Improvement of Medical and Health Care in Jails

ACTION: Filed.

Inadequate medical care in jails has been a long-standing problem for the criminal justice system in this country. Within the past few years, this problem has been the subject of many legal suits. Generally speaking, judges throughout the country have been finding that prisoners have a constitutional right to adequate medical care. In the words of an Arkansas circuit court judge, "If Arkansas is going to operate a penitentiary system, it is going to have to be a system that is countenanced by the Constitution of the United States."

Recognizing the need for national direction with this problem, the American Medical Association applied to the United States Justice Department Law Enforcement Assistance Administration for a grant to develop health care standards for jails across the country. In 1976 the American Medical Association sub-contracted with the state medical association in Indiana, Georgia, Maryland, Wisconsin, Michigan and Washington. The project was designed to take three years, with the first year being devoted to development and testing of standards. The second year was designed for implementation and further testing of standards in select pilot jails. The third year was designed for expansion of the project into non-pilot jails.

The Indiana State Medical Association has been working with the county jails in Lake, Morgan, Owen, Greene, Monroe and Brown counties since 1976. During the 1977 fiscal year, beginning in March 1977, the implementation phase was begun. At the present time, we have received accreditation applications from both the Greene and Marion county jails.

Under the direction of Dwight Schuster, M.D., medical director for the ISMA jail project, ISMA staff is actively working with jail personnel in all seven Indiana pilot jails. It seems likely that all Indiana pilot jails will reach accreditation status by the end of this fiscal year.

The physician community has been receptive to the project, volunteering services and, in one case, medical equipment to a jail.

DWIGHT SCHUSTER, M.D.
Chairman

Ad Hoc Committee on the Impaired Physician

ACTION: Filed.

The Ad Hoc Committee on the Impaired Physician met on May 5, June 2, and July 7, 1977, since being appointed by John W. Beeler, M.D., president, ISMA.

A major portion of the Committee's time was devoted to investigating programs started in other states and developing a program for Indiana physicians in cooperation with the Medical Licensing Board. In order to provide better coordination between this Committee and the Medical Licensing Board, Dr. Beeler was requested to expand the committee to include a member of the Medical Licensing Board. This done, and John H. Mader, M.D., was appointed.

An Impaired Physician Survey was developed by the Committee and submitted to Dr. Beeler for approval for distribution to medical societies and other medical groups. The survey was approved and was initially distributed to 60 physicians attending a continuing education session for family practice physicians. The results of the survey, completed by 42 of the physicians, showed that 81% believed there is a significant problem in Indiana related to the impaired physician; 93% felt they didn't have adequate facilities or programs in their area for recognition and rehabilitation of the impaired physician; 43% didn't know where to refer a colleague who was having problems with emotional disturbance, alcohol or drug dependence; 98% felt there is a need for an organized program; 86% also felt such a program should have some coercive back-up. This survey has recently been sent to presidents of county medical societies and hospital staffs, and will be pre-

sented to the state psychiatric society for its information and feedback. In addition, the psychiatric society will be requested to submit a list of physicians who would be willing to treat impaired physicians.

The Committee believes that the News Flash should carry a small article informing the physicians that a committee has been formed to develop a program of recognition and treatment, and that the Auxiliary be provided with the same information for inclusion in "The Hoosier Doctor's Wife." This has been done.

It was the unanimous opinion of the Committee that a resolution should be written to make this committee a standing committee of the Association and to include both general and specific goals of the Committee. The resolution has been written and will be submitted for approval at the 128th annual convention of the ISMA.

The Committee has requested space at the annual convention for a scientific exhibit which will be called, "The Impaired Physician: A Treatable Problem." The Executive Committee approved the Committee's request to spend \$100 for purchase of the informational packet put out by the Washington State Medical Association, which will be used in the exhibit.

The Committee has scheduled another meeting for August 11. It is anticipated that the Committee will continue to meet right up to the date of the annual convention, in order to facilitate its plan of action and to work on the exhibit. A supplemental report will be made at the annual convention to the reference committee assigned to hear its resolution.

GERALD P. JOHNSTON, M.D.
Chairman

RICHARD W. CAMPBELL, M.D.;
THOMAS E. LUNSFORD, M.D.;
WALLACE R. VAN DEN BOSCH, M.D.;
JOHN H. MADER, M.D.

Medical-Legal Review Committee

ACTION: Filed.

The Medical Legal Review Committee and staff handled a minimum of routine problems presented it without meeting during this past year. However, the committee chairman strongly endorses the future utilization and continuation of this committee. The Indiana State Medical Association Ad Hoc Committees curtailed activities the Medical Legal Review normally handles.

The Medical Legal Review Committee will continue to assist the Association in whatever way possible in solving the interface of problems affecting the Legal and Medical professions.

JOHN W. BEELER, M.D.
Chairman

Reports of Commissions

Legislation

ACTION: Adopted.

The 100th General Assembly and the May 23, 1977, Special Session of the General Assembly were very active periods for the ISMA Commission on Legislation. The Commission met four times during some very severe weather, but the attendance was excellent. Approximately 1,200 bills were introduced and 147 identified as having a potential impact upon the practice of medicine in Indiana. The ISMA Legislative Commission considered the following important health-related legislation:

1. HB 1664—PEER REVIEW (Resolution 76-23)

This bill provided immunity from civil tort prosecution for those persons participating in organized peer activities performing evaluation of provider qualifications and patient care rendered. The bill was signed by the Governor.

2. HB 1808—CATASTROPHIC INSURANCE (Resolution 76-24)

This bill was introduced by Dr. E. Henry Lamkin, majority floor leader, House of Representatives, in response to the Indiana State Medical Association House of Delegates' Resolution. The legislation required the State of Indiana to solicit bids for catastrophic insurance from private carriers and make the insurance available to citizens of Indiana. The bill was not considered by committee.

3. HB 1433—DEFINITION OF DEATH (Resolution 76-29)

Representative Lamkin introduced legislation which defined death as cessation of spontaneous brain activity when the patient was on artificial support equipment. The bill passed the House but was not considered in the Senate.

4. HB 1050/HB 2076—GENERIC SUBSTITUTION

The House of Delegates directed the ISMA to oppose legislation which allowed for generic substitution of prescription drugs. Two bills were introduced and neither received a committee hearing.

5. HB 1418—CERTIFICATE OF NEED (Resolution 76-28)

The House of Delegates directed the ISMA to oppose any certificate of need legislation. This bill required physicians to seek a certificate of need prior to the construction of facilities costing more than \$100,000 from the local

HSA, SB 542 required health care facilities to be subjected to Section 1122 of the Social Security Act (Medicare/Medicaid Reimbursement for Capital Expenditures). The definition of a health care facility was expanded to read the same as the certificate of need definition and, therefore, ISMA opposed the bill. Neither bill passed.

6. MEDICAL EXAMINER

The Commission requested outside counsel to draft legislation for the removal of the coroner's office as a constitutional office substituting it with a qualified physician medical examiner. A vehicle bill was reserved for this purpose, but the content was not provided.

7. HB 1439—DEDICATED FUNDS FOR LICENSING BOARDS

The Commission requested legislation for a change in the funding of the Medical Licensing Board. This bill was introduced to provide dedicated funding for licensing boards. The bill passed but was amended to provide for the conduct of a study to determine the feasibility of the dedicated funding method for the licensing boards.

8. HB 1427—PHYSICIAN ASSISTANTS

The Commission supported the amendment of the Medical Practice Act which defined the physician assistant and generally outlined the duties which he could perform under the supervision of his employing physician. The final language omitted any provision for a so-called Duffy Amendment. The bill was signed into law by the Governor.

9. HB 1637—MEDICAL REVIEW PANEL

The ISMA supported the technical amendments introduced by the Governor's Study Commission on Medical Malpractice this legislative session. The amendments provided a mechanism by which each side in a malpractice suit selected a member chairman within a certain number of days. The legislation was signed by the Governor.

10. HB 1366—RIGHT TO DIE

This bill allowed a patient to direct the physician to allow termination of life support systems in terminal cases. The bill received a hearing but was not reported out of committee.

11. HB 1405—LAETRILE

The Governor vetoed this bill because of the significant changes made in the conference committee

report. The present statute permits laetrile treatment in lieu of regular scientifically proven treatment. Additionally, laetrile can be used as a dietary supplement. The conference committee report further amended the legislation by stripping the State Board of Health and the State Pharmacy Board of any regulatory authority. The General Assembly overrode the Governor's veto on April 30, 1977. The bill became law on June 1, 1977.

An added tool for the Legislative Commission this year was the timely addition of Mr. Richard King as Legislative Analyst. Mr. King worked many hours in keeping track of the movement of bills through the House and Senate committees. He also ably expained to the legislators ISMA's position on bills which concerned the practice of medicine. The Commission wishes to thank him for his efforts and we look forward to next year's session of the Legislature.

I would like to thank the members of the Commission and the Board of Trustees for their attendance and input at the meetings in spite of the bad winter. I believe that holding combined meetings of the ISMA Commission and the IAFP Legislative Committee was most beneficial.

The Commission also wishes to thank Dr. E. Henry Lamkin for the help and leadership he provided in guiding important medically related legislative issues through the 100th session of Indiana's General Assembly. The Commission believes that this session was a most successful one for ISMA, and is well aware that this success could not have been accomplished without his help.

Last, but not least, the Commission wishes to thank Mr. Foy and the entire ISMA staff for their cooperation and endless hours of work which made the Commission's meetings possible as well as successful.

LEONARD W. NEAL, M.D.
Chairman

JAMES A. MARVEL, M.D.; PAUL J. WENZLER, M.D.; PETER H. LIVINGSTON, M.D.; WILLIAM F. BLAISDELL, M.D.; WILLIAM STRECKER, M.D.; JOHN A. DAVIS, M.D.; JOHN G. PANTZER, M.D.; RICHARD L. REEDY, M.D.; JOHN A. KNOTE, M.D.; RICHARD L. GLENDENING, M.D.; JERRY L. STUCKY, M.D.; MALCOLM O. SCAMAHORN, M.D.; JOHN B. WHITE, JR., M.D.; PHILIP N. ESKEW, M.D.; PELAYO B. CABRERA, M.D.; JOSEPH M. BLACK, M.D.; ERNEST R. BEAVER, M.D.; RONALD BLANKENBAKER, M.D.; MRS. R. M. SCHLEINKOFER (Auxiliary); MRS. F. O. MACKEL (Auxiliary); WILLIAM POND (Student Member).

Medical Education

ACTION: Adopted.

The Commission on Medical Education and its Committee on Accreditation held three meetings this year. The following actions were taken:

1. New hospitals and specialty societies have been surveyed and CME accredited. Hospitals initially accredited for a two-year period are now being resurveyed and accreditation renewed. Several societies made application, but action was deferred pending additional information.

CME accreditation or reaccreditation was approved for:

* Indiana Philippine Medical Society
Indiana Chapter American College of Surgeons

*Indicated reaccreditation.

* Huntington Memorial Hospital
Good Samaritan Hospital Vincennes

Fort Wayne Anesthesia Society

* St. Mary's Medical Center, Gary
Scheduled for review by the Accreditation Committee and the Commission on Medical Education at the Aug. 28, 1977, meeting are:

Indiana State Board of Health seminars

Indiana Academy of Family Physicians

* Gary Methodist Hospital

* St. Catherine Hospital—East Chicago

* St. Joseph Hospital—Kokomo
Welborn Baptist Hospital—Evansville

St. Joseph County Medical Society

2. Scientific programs for ISMA State Convention were reviewed, thus permitting attendees at these scientific programs to include those category 1 hours in their PRA application. Hours allowed will be published in *The Journal* for each program. Validated cards will be available to attendees for their CME records of programs attended. Liaison members of the Commission on Medical Education were named to meet with the Commission on Convention Arrangements to aid in providing Category 1 accreditation.

3. In efforts to further stimulate interest in CME and recognize those physicians who are participating the Commission has:

3.1 Issued a letter to all Indiana physicians urging them to participate in CME and to apply for the Physician's Recognition Award. This will be enclosed with the 1977 PRA Booklet and Application to be

- mailed by the AMA in August.
- 3.2 Obtained printouts of all PRA recipients in Indiana each month. Issued a gold Distinguished Membership card and letter of congratulations to each ISMA member listed.
 - 3.3 Published names of PRA recipients in *The Journal* each month.
 - 3.4 Placed insert in *The Journal* to be detached and used for record of CME hours each physician attains. Similar insert will be repeated in a fall 1977 issue and will repeat the PRA requirements.
 - 3.5 Purchased publications prepared by the Illinois Council on CME which will be offered to smaller hospitals and to DMEs of accredited hospitals. "How to Start a CME Program," "Case Discussion and Problem Solving" and "Planning CME Programs That Fit Staff Interests."
 4. Facing the very controversial subject of mandatory CME for ISMA membership and/or legislated CME for recertification, the Commission has recommended that the Board of Trustees consider a three-year voluntary CME requirement for ISMA membership, followed by a possible mandatory requirement.
 5. The Commission likewise has recommended to Dr. Beaver of the Indiana Licensing Board that any regulations they develop on relicensure conform in pattern and time intervals to the AMA's PRA.
 6. The following Commission members provided liaison with other groups:

Board of Trustees:
 Franklin Bryan, M.D.
 Indiana Medical Licensing Board:
 Ernest R. Beaver, M.D.
 Accreditation Committee:
 Eugene Gillum, M.D.
 AIDME:
 Franklin Bryan, M.D.
 Division of Postgraduate Education, I.U.:
 John Phillips, M.D.
 Convention Arrangements:
 Cleon Schauwecker, M.D.
 John Roscoe
 Indiana Academy of Family Physicians:
 Eugene Gillum, M.D.
 Student Affairs:
 Phillip Doering, M.D.
 House Staff:
 Gary Wright, M.D.
 Commission on Legislation:
 Steven C. Beering, M.D.

STEVEN C. BEERING, M.D.
Chairman

ROBERT H. OSWALD, M.D.; DAVID A. BYRNE, M.D.; RICHARD RIEHL, M.D.; LESLIE M. BAKER, M.D.; CLE-

ON SCHAUWECKER, M.D.; JOHN LING, M.D.; DONALD M. SCHLEGEL, M.D.; EUGENE M. GILLUM, M.D.; T. NEAL PETRY, M.D.; NICHOLAS L. POLITE, M.D.; SHOKRI RADPOUR, M.D.; RONALD H. SCHEERINGA, M.D.; WALLACE S. TIRMAN, M.D.; ERNEST BEAVER, M.D.; FRANKLIN A. BRYAN, M.D.; GEORGE ALCORN, ROBERT CHEVALIER, M.D.; EDWIN S. McCLAIN, M.D.; JOHN ROSCOE, JOHN PHILLIPS, M.D.

Subcommission on Accreditation
 EUGENE M. GILLUM, M.D.
Chairman

THOMAS SPAIN, M.D.; MICHAEL A. HOGAN, M.D.; DONALD M. SCHLEGEL, M.D.; WILLIAM FECHTMAN, M.D.; WILLIAM D. RAGAN, M.D.; RAYMOND PIERCE, JR., M.D.; JEFFREY KELLAMS, M.D.; CHARLES HELMEN, M.D.; EMMETT PIERCE, M.D.; STEVEN C. BEERING, M.D.; FRANKLIN A. BRYAN, M.D.; DAVIS W. ELLIS, M.D.; SHOKRI RADPOUR, M.D.; RALPH WILMORE, M.D.; GARY WRIGHT, M.D.; PHILLIP DOERING, M.D.; NEALE A. MOOSEY, M.D.; JOHN PHILLIPS, M.D.; JOHN ROSCOE; JOHN OSBORNE, M.D.

Medical Services

ACTION: Filed. (Further reference: Resolutions 77-33 and 77-48.)

This is a preliminary report of the Commission on Medical Services to meet publication requirements. Completion of Commission activities and resolutions and recommendations will be prepared and submitted by Convention time.

The consolidation of preceding commissions' work was continued. Additionally, new areas of endeavor have been sought and evaluated.

VOLUNTARY HEALTH AGENCIES: The annual approval of statewide Voluntary Health Agencies has been discontinued as a commission activity on a regular basis. The services of the ISMA will be available to assist the agencies in areas relating to medical involvement. The ISMA will continue to review, informally, the annual report of the agencies.

INSURANCE: The concept of an in-house broker was reviewed and felt to be nonproductive currently. Development of a "captive" insurance company would not be advisable at present.

MALPRACTICE: While not directly responsible for this activity, the commission continues to maintain contact with this field, particularly in regard

to premiums and also experiences with claims-made type policies.

HEALTH: Health insurance programs were reviewed as best as possible prior to contract renewal. There was an inadequate presentation of utilization experience. The Commission was concerned not so much with the coverage or its major medical provisions, but rather with the quality of claims processing. The commission recommended as an innovation that the ISMA process its members' claims as a form of self-administration. While this recommendation was not accepted, it did result in the appointment of an *ombudsperson* on the Blues company payroll to consult with ISMA members and their dependents on claims problems.

AGING: The Subcommission on Aging has been active under the leadership of Albert Donato, M.D.

1. A roster of directors of Indiana nursing homes is being compiled.

2. Liaison with the Department of Public Welfare concerning nursing home matters and medical care has been developed.

3. The commission is engaged in the study of fees and parameters of Medicaid programs for nursing homes.

COMPUTER STUDY: The commission participated in and reviewed the ISMA computer application study. While an in-house computer would serve well for housekeeping functions, it would seem that in addition to a computer the Association could benefit in its deliberation from the professional services of a data gatherer and analyst of other data systems, such as Blue Shield, HSAs, government medical programs (Medicare and Medicaid) and members' insurance programs.

SPORTS AND MEDICINE: After a complete breakdown in this field of leadership and purpose, the commission has reviewed ongoing ISMA activity in this area and developed new medical leadership. Further details will be refined in the next few weeks and submitted in the supplementary report.

WELFARE: Meetings have been held with Mr. Wayne Stanton, administrator of Public Welfare, and James O. Price, M.D., Director of Medical Affairs, IDPW, regarding the medical field. Meetings have been arranged to study Medicaid and other welfare programs. Studies of the new Medical Management Information System (MMIS) are being made. The new data reporting system has been available for only six months. An ongoing system of evaluating these reports for

the purpose of making appropriate recommendations to the administrator on the various programs will in all likelihood be developed.

The chairman wishes to thank staff, guests and particularly the members of the commission for their interest and attendance and valuable input.

LEE TRACHTENBERG, M.D.

Chairman

WALLACE ADYE, M.D.; ROGER F. ROBISON, M.D.; EVERETT E. BICKERS, M.D.; ROBERT O. ZINK, M.D.; PAUL E. HUMPHREY, M.D.; ROBERT R. TAUBE, M.D.; ALBERT M. DONATO, M.D.; THEODORE R. HAYES, M.D.; GERALD BOUGHER, M.D.; R. JAMES BILLS, M.D.; R. WYATT WEAVER, M.D.; JACK W. HANNAH, M.D.; ROBERT R. KOPECKY, M.D.; HAROLD MARSHALL TRUSLER, M.D.; RICHARD B. SCHNUTE, M.D.

Public Information

ACTION: Filed. The subject of Tel-Med referred to the Board of Trustees.

The Commission on Public Information met in December 1976, March and May 1977.

Once again, the Commission took up the matter of an Accountability Session and, after much discussion, decided to table indefinitely any further debate on this. Instead the Commission voted to initiate, on a trial basis, as part of its function, a review hearing session at each of its meetings for constructive input from appropriate outside agencies and individuals regarding any and all areas of medicine and health care services in the state of Indiana that would relate to ISMA. The Commission will review the information and refer its conclusions to the appropriate commission or committee for information or action. The Commission will reserve the right to accept or reject the requests based on merit and/or availability of time. The Commission expects to start holding these hearings during 1978.

At all three meetings funding for the Tel-Med program was discussed. At the request of the Commission, staff sent letters to several foundations and organizations requesting financial support for the Tel-Med Program, but in each case the response was "We think it is an excellent program, but we are not able to donate." With the approval of the ISMA Board of Trustees, funding was also solicited from the three HSAs and the State Health and Development Agency. The results were the same. The Commission recommended that the Tel-Med program be continued statewide, without the use of WATS lines, for three months and a record kept to find out if callers outside the Indianapolis area were will-

ing to use the program when they had to pay for the call. The Commission requested a transfer of \$5,000 from its budget to the Tel-Med fund in order to conduct this study. The Executive Committee, with authority from the Board of Trustees, decided the best solution was to discontinue the program and continue discussions with other parties who expressed an interest in taking over the program. The program, much to this Commission's regret, was discontinued on June 6, 1977.

It was noted by the Commission that ISMA's Speakers' Bureau was not being used to the extent that all had hoped it would be. The Commission requested staff to prepare a letter that would be sent to each county society secretary with a brochure from the Hopkins Syndicate, which handles the program for ISMA, requesting them to publicize the availability of the Speakers' Bureau. This was done, but the requests for speakers are still below expectations.

Three films on socialized medicine were borrowed from the Louisiana State Medical Association to determine if they would be worth purchasing. Drs. Acher, Middleton, and Ritz showed the films to non-medical groups in their area and reported a good response. The Commission purchased two copies of each film and their availability was publicized in the News Flash.

The Commission also viewed a 24-minute, 16 mm color film, "Together We Are Something" and decided it could be a useful tool for ISMA's field representatives to use in interesting young physicians to become active in their county and state societies. The film was purchased and the field representatives were requested to develop an effective program to present the film.

A physician survey on Substance Abuse was approved for distribution by the Department of Mental Health with the stipulation that the data from the questionnaire be made available to this Commission for approval of any conclusions. The Commission felt there was a definite need for such information to aid in the planning of clinics and to help motivate funding for substance abuse programs.

At the request of John W. Beeler, M.D., president, ISMA, the Commission was requested to come up with a good statement of opposition to Certificate of Need. The Commission recommended that the Board of Trustees accept Report C of the AMA's Council on Medical Service as ISMA's position on Certificate of Need. It states:

As much as certificate of need is intended to cut costs, avoid duplication, increase accessibility, etc., it can also stifle competition, be extremely time-consuming and expensive, and may not appropriately address the problem of

duplication of facilities and services. Competition should be encouraged and new types of incentives should be created for the health and medical care providers. Certificate of need should be more responsible to the public disclosure in order to maintain reasonable cost. Caution should be taken so that particular special interests don't have control of the certificate of need process. Finally, prudent judgment should be the hallmark of certificate of need legislation at all levels.

The Commission also discussed the advisability of publicizing the need for Catastrophic Health Insurance without knowing more about the availability and cost. The Commission was concerned about the claim made by HIAA that 95% of Indiana's population under age 65 had coverage in the amount of \$10,000. Therefore, the Commission decided to table any further discussion until the Medical Services Commission has had an opportunity to investigate the matter and provide this Commission with a report.

The report on Criteria and Standards for Perinatal Health Services was looked at by the Commission and was judged unacceptable in several areas. The Commission felt the report offered solutions without identifying specific problems. The Commission recommended that ISMA's Committee on Perinatal Health Services be requested to review the report again in search of other alternatives to transporting patients and to closing down facilities now available to Indiana patients. At a later meeting the Commission was made aware of the letter James A. Harshman, M.D., chairman of the Board of Trustees, sent to William T. Paynter, M.D., State Board of Health Commissioner, concerning this matter. The Commission sent a letter to Dr. Harshman complimenting and supporting him on his correspondence to Doctor Paynter.

U.S. Standard Certificate of birth, death and a report of induced termination of pregnancy were looked at for format and content at the request of the State Board of Health. The Commission requested sections 12 and 13 on the Certificate of Live Birth be deleted because they were not necessary and invaded privacy.

A report that an award be offered by the ISMA to the physician doing the most Medicaid work as a way of offset some of the bad publicity in this area was rejected by the Commission.

The Commission also made its selection for the Journalism Awards and for the Physician Community Service Award. These awards will be presented at the Indiana State Medical Association's annual meeting in October.

At the direction of the ISMA Board of Trustees, a seminar on health care costs

was discussed at some length at the final meeting of the Commission. Dr. Priddy appointed Dr. Charles Egnatz to chair a special committee of this Commission to look into organizing such a seminar. Dr. Ross Egger and Dr. Albert Ritz, were appointed to the committee with Dr. Priddy, serving as an ex-officio member. The Commission informed the Board of Trustees that it is in favor of such a seminar and requested the Board's approval and direction for site and cost. The Commission will move ahead when the Board has had an opportunity to discuss the matter and respond.

The Commission adopted the Scoliosis Screening Program of the Vanderburgh County Medical Society and sent the material to each county medical society for implementation. *The Journal* was also requested to include an article regarding the necessity for such a program and reminding all physicians to check for scoliosis in children.

Several other letter requests were han-

dled by the Commission regarding: Emergency Medical Information Card, ISMA Membership Decal, Hypoglycemia Club, AMA Public Service Announcements, Immunization, Health and Humanities, Women in Medicine—Oral History Project, Diabetic Exchange List, Names of People and Places Responsible for Newly Developing Technics and Procedures in Different Fields of Medicine in Indiana, and Scriptographic Booklets.

As chairman of the Commission, I wish to thank the members of the Commission for their participation. The meetings were productive and, I feel, will help enhance the public relations of the Association.

MARVIN E. PRIDDY, M.D.
Chairman

ALBERT S. RITZ, M.D.; THOMAS O. MIDDLETON, M.D.; KENNETH E. HINES, M.D.; ROBERT P. ACHER, M.D.; GREG LARKIN, M.D.; RALPH LEWIS REA, M.D.; ROBERT W. HAR-

GER, M.D.; KENNETH J. AHLER, M.D.; CHARLES D. EGNATZ, M.D.; JOHN W. LUCE, M.D.; HARRY G. BECKER, M.D.; ROSS L. EGGER, M.D.; GABRIEL J. ROSENBERG, M.D.; HARRY G. MCKEE, M.D.; MIKE GOLER (Student Member).

Constitution and Bylaws

Presented by:

JOHN B. GUTTMAN, M.D.,
Chairman

CLAUDE JAMES MEYER, M.D.,
IVAN T. LINDGREN, M.D., C. G. CLARKSON, M.D., I. E. MICHAEL, M.D., JOHN SAALWAECHTER, M.D., FRANK M. STURDEVANT, M.D., ROBERT M. BROWN, M.D., WILLIAM R. CLARK, SR., M.D., LESTER H. HOYT, M.D., JOHN RECORDS, M.D., WALLACE SCEA, M.D.

ACTION: Adopted and amended.

Constitution and Bylaws

Constitution

ARTICLE I—TITLE AND DEFINITION

The name of this organization is the Indiana State Medical Association. It is the federacy of Indiana county medical societies.

ARTICLE II—PURPOSES

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the state of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education; to promote friendly relations among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care and public health so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III—COMPONENT SOCIETIES

Component societies are those county and district medical societies contained within the state of Indiana, and who hold charters from this Association.

ARTICLE IV—MEMBERS

The Indiana State Medical Association is composed of individual members of county medical societies and others as shall be provided in the Bylaws.

ARTICLE V—HOUSE OF DELEGATES

The legislative and policy-making body of the Association is the House of Delegates composed of elected representatives and others as provided in the Bylaws. The House of Delegates shall transact all business of the Association not otherwise specifically provided for in the Constitution and Bylaws and shall elect the general officers, except trustees, as otherwise provided in the Bylaws.

ARTICLE VI—OFFICERS

The general officers of the Association shall be

a president, president-elect, immediate past president, treasurer, assistant treasurer, speaker, vice speaker, and the trustees. Their qualifications and terms of office shall be provided in the Bylaws.

ARTICLE VII—TRUSTEES

The Board of Trustees is composed of trustees and alternate trustees elected by the component district medical societies, and the president, the president-elect, treasurer, immediate past president, the assistant treasurer, with power to vote only in the absence of the treasurer, and the speaker and vice speaker without power to vote and the executive director without power to vote. The alternate trustees have power to vote only in the absence of the trustee.

The Board of Trustees shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed by the law governing directors of corporations or as may be prescribed in the bylaws.

ARTICLE VIII—THE CONVENTION

The House of Delegates and the general scientific program shall be convened annually and at such other times as deemed necessary or as provided in the Bylaws, in cities recommended by the Board of Trustees and approved by the House of Delegates.

ARTICLE IX—FUNDS, DUES AND ASSESSMENTS

Funds may be raised by annual dues or by assessment of the active members on recommendation of the Board of Trustees and after approval by the House of Delegates, or in any other manner approved by the Board of Trustees as provided in the bylaws.

ARTICLE X—AMENDMENTS

The House of Delegates may amend this Constitution at any convention provided the proposed amendment shall have been introduced at the preceding annual convention and provided two-thirds of the voting members of the House of Delegates vote approval and provided that it shall have been published twice during the year in *The Journal* of the Association.

Bylaws

DIVISION ONE—MEMBERSHIP

CHAPTER I—QUALIFICATIONS, ELECTION AND RIGHTS

Section 1. Regular Member. The term “regular member” as used in these Bylaws shall include Active, Senior, Military Service Member, Veterans Administration Member, Public Health Service Member, Disabled Member, Medical Student Member, Interns and Residents, of component county medical societies who hold the degree of Doctor of Medicine or Bachelor of Medicine, or who hold an unrestricted license to practice medicine and surgery unless the license has been surrendered because of retirement as required in the Medical Practice Law. As to Interns and Residents they shall be serving in training programs approved by the Association, or if a Medical Student they shall be enrolled in a medical school approved by the Association. All regular members are entitled to exercise the rights of membership in their county and state associations, including the right to vote and hold office, as determined by their respective county medical society and/or their state association.

A regular member who is a member in good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association, provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect.

Section 2. Special Member. The term “special member” as used in these Bylaws, unless otherwise indicated, shall mean Associate Members and Honorary Members as defined in Section 3, Chapter I of the Bylaws of the Indiana State Medical Association. Special members shall not be entitled to vote or hold office in this association.

Section 3—Members by Category

A. Active Members. The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant active membership therein on a basis that does not include membership in the district medical society and in the Indiana State Medical Association.

B. Interns and Residents. Interns and Residents who hold membership in the Indiana State Medical Association shall have all the rights and privileges of this Association.

C. Senior Members. Senior Members shall be eligible for Senior Membership on January 1 following their 70th birthday and they shall be physicians of the State of Indiana and who have held their membership in the Indiana State Medical Association for 20 years or more; or who have held membership in the Indiana State Medical Association or in some one or more other like state organization which is a component state organization of the American Medical Association, for a combined total of 20 years or more, and who, upon their application, have been certified to the Executive Director as eligible for such membership by the county societies of which they are members. It shall be the duty of the county medical society to verify, through the office or offices of any other state organization or organizations, the fact of membership therein when such membership

is claimed as part compliance with the eligibility requirement of 20 years of membership.

D. Honorary Members. Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold elective office. They shall not be required to pay membership dues in the State Association. Such honor may be conferred by the vote of the House of Delegates.

E. Disabled Members. Disabled members shall consist of physicians of the State of Indiana who are certified by a member physician to be permanently disabled and no longer able to practice medicine and who continue to reside in the State of Indiana. Proof of permanent disability shall be by notification to the Executive Director of the Association by the secretary of the county medical society in which such permanently disabled physician holds membership.

All such disabled members shall receive membership cards and THE JOURNAL of the Association without charge.

F. Distinguished Members. Active members who have fulfilled the American Medical Association's Physician Recognition Award requirements of 150 hours for three years of continuing medical education as a minimum shall be designated as Distinguished Members.

G. Military Service Members, Veterans Administration Members and Public Health Service Members. Any physician who is actively engaged in the military service, veterans administration, or public health service shall be eligible for membership in the Association with payment of regular dues; they shall receive THE JOURNAL.

H. Members who have chosen voluntary inactivity from the practice of medicine before the age of 70 shall only be required to pay membership dues in the amount of one half of full membership dues applicable at the time.

I. Student Members. Medical students who attend an accredited medical school in Indiana.

Student members may be represented in the House of Delegates with the power to vote. They shall be entitled to send one delegate or one alternate. Student delegate and alternate are to receive THE JOURNAL of the State Association.

Section 4—Rights and Privileges of Members

A. Suspension or Revocation of License

No person whose license to practice medicine has been suspended or revoked or who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association or of a component county society, nor shall he be permitted to take part in any of their proceedings until he has been relieved of such disability. This shall not apply to the physician who has surrendered his license because of retirement under the provisions of the Medical Practice Law.

B. Attendance at Annual Convention

Each member in attendance at the Annual Convention shall register by indicating the component society of

which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that convention. No member shall take part in any of the proceedings of an Annual Convention until he has complied with the provisions of this section.

C. Rights and Privileges by Membership Category

Rights and Privileges of Members. Active members, intern and resident members, senior members, military service members, public health service members, disabled members, honorary members, student members and inactive members shall have the same rights and privileges except as follows:

(a) Senior members shall not be required to pay membership dues in the State Association.

(b) If senior members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

(c) Senior members who desire the benefit of medical defense as provided by the Bylaws of this Association shall pay the amount stipulated in Section 1, Chapter XVI of the Bylaws for this coverage.

CHAPTER II—DUES, FUNDS AND ASSESSMENTS

Section 1—Dues

A. Income and Expenses

Funds for carrying on the activities of this Association shall be raised by the following means:

(a) Membership dues to be collected may be collected by the Indiana State Medical Association or by the component county societies. The amount of dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

(b) Voluntary contributions.

(c) Revenues derived from the Association's publications.

(d) Upon recommendation of the Board of Trustees or any other manner approved by the House of Delegates.

Funds shall be appropriated by the Board of Trustees to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions recommending the appropriation of funds by the House of Delegates must be referred to the Board for recommendation before final action is taken by the House of Delegates.

B. Change in Dues Structure

The final vote on any issue calling for changes in dues or in dues structure shall be by roll call vote of the House of Delegates. Each member's vote shall be permanently recorded and no suspension of this rule will be allowed on the final vote on such an issue.

DIVISION TWO— ANNUAL CONVENTION ACTIVITIES

CHAPTER III—CONVENTION AND MEETINGS

Section 1—Annual Convention

The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

Section 2—Selection of Site

The House of Delegates shall select the place five years in advance for holding the Annual Convention. The time for the convention shall be fixed by the Board,

and the Board shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

Any of the component member county societies wishing to invite the Indiana State Medical Association to hold its annual meeting in its locality shall submit an invitation in writing at least five years in advance to the Board of Trustees. The Board of Trustees shall make an investigation of the facilities and in turn recommend the location to the annual meetings for concurrence by the House.

Section 3—Special Meetings

Special meetings of either the Association or the House of Delegates shall be called by the President upon receipt of a petition signed by thirty delegates or one hundred members. The signed petition shall contain the names of at least ten delegates or thirty-four members from each of at least three Board districts. Upon receipt by the President of such a petition, the President shall within thirty days thereafter issue a call for such special meeting at a time and place to be fixed by the President. The President, in specifying the time of such special meeting, shall fix the same as soon thereafter as reasonable and suitable arrangements can be made.

Section 4—General Meetings

General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President may be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Commission on Convention Arrangements, with the sanction and approval of the officers.

Section 5—Appointment of Committees

The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Section 6—Scientific Papers

All scientific papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive Director when read.

Section 7—Appropriations

The Board of Trustees shall appropriate from the funds of the Association such an amount as in the discretion of the Board shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such Convention. The funds so appropriated shall, upon the approval of the Executive Committee, be expended at the direction of the Commission on Convention Arrangements appointed by the President for the Convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the Association.

CHAPTER IV—SPECIALTY SECTIONS

Section 1—Official Sections

During the Annual Convention the Association in addition to the general meetings may hold the following

section meetings:

- a. Surgical.
- b. Internal Medicine.
- c. Eye, Ear, Nose, and Throat.
- d. Anesthesia.
- e. Family Physicians.
- f. Obstetrics and Gynecology.
- g. Preventive Medicine and Public Health.
- h. Radiology.
- i. Nervous and Mental Diseases.
- j. Pathology and Forensic Medicine.
- k. Pediatrics.
- l. Directors of Medical Education.
- m. Cutaneous Medicine.
- n. College Health Physicians.
- o. Interns and Residents.
- p. Allergy.
- q. Urology.
- r. Orthopedic Surgery.
- s. Emergency Medicine.
- t. Neurological Surgery.

All future sections will be formed by properly constituted resolution which shall include the signatures of a minimum of 15 members or 25% of the members, whichever is greater, who are practicing that specialty in the state of Indiana.

Section 2—Officers

The officers of each section shall be a chairman, a vice-chairman, and a secretary, and they shall preside over the meetings of the sections and shall be responsible to the Commission on Convention Arrangements for the section speakers and papers.

Section 3—Officer Elections

The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

Section 4—Restriction on Meetings

No section meeting shall be allowed to conflict with a general meeting.

DIVISION THREE— BUSINESS AND LEGISLATION

CHAPTER V—HOUSE OF DELEGATES

Section 1—Composition

The House of Delegates shall be the legislative and policy-making body of the Association and shall consist of (1) Delegates, or their designated alternates, elected by the component county societies; (2) the Trustees, or their designated alternates, and (3) the ex-presidents of the Indiana State Medical Association. The delegate or their designated alternate delegate elected by their respective section shall also be a member but without power to vote. The following shall be ex officio members: The President, the President-Elect, the Executive Director, the Treasurer and Assistant Treasurer of this Association, the Speaker, the Vice Speaker and the delegates to the American Medical Association, all without power to vote, except the Speaker and Vice-Speaker who shall vote as set forth in Chapter VI, Section 3 (F) and (G) hereafter.

Section 2—Meetings

The House of Delegates may meet on the day before the date set for the beginning of the general registration of the attendance at the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the general or section meetings.

It shall meet on the last day of the Annual Convention for the completion of any business previously introduced. for the election of officers for the ensuing year, and The order of business shall be arranged as a separate section of the program. Nominations for officers of the Association may be made at any meeting of the House of Delegates.

Section 3—House Admission

All sessions of the House of Delegates shall be open to all members in good standing of this Association for observation.

Section 4—Delegate Apportionment

Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and Bylaws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate and one alternate delegate who shall be a resident of the county he represents as a delegate or alternate delegate and who shall be selected by the physicians residing in such county. The student delegate shall be seated with full power to vote. In the absence of the student delegate, the alternate shall be seated with full power to vote.

The number of delegates to which each component society is entitled shall be based upon the number of members on record in the office of the Executive Director in good standing with current dues fully paid as of December 31 of the preceding year.

All sections listed in Chapter III, Section 1, of these Bylaws shall be entitled to send to the House of Delegates each year one delegate or one alternate delegate without the power to vote.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive Director of this Association on or before February 1, prior to the Annual Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credential card as a delegate or alternate, properly signed by the secretary of his county medical society, executive secretary or executive director of the larger societies, is presented to the Committee on Credentials at the time of the Annual Convention.

Section 5—Quorum

Fifty (50) delegates shall constitute a quorum.

Section 6—Responsibilities

A. Delegates to American Medical Association

The House of Delegates shall: elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

B. Organizing Districts and Sections

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Trustee District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. Trustee districts shall be defined by the House of Delegates.

The House shall divide the state into Trustee districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county

societies, and no others, shall be members of such district societies.

C. Authority to Appoint Special Committees

The House shall have authority to appoint committees for special purposes from among members of the Association who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

Section 7—Resolutions and Proposals

The House of Delegates shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Proposals calling for appropriations of funds by the House of Delegates shall be accompanied by a fiscal note and shall be submitted to the Executive Committee and the Board for review, presentation and recommendation for final action of the House. No proposal calling for appropriations shall be considered if not accompanied by a fiscal note.

All resolutions to be presented to the House of Delegates for action shall be prepared and mailed to the Executive Director of the Association so that he will receive them not later than 45 days prior to the meeting of the House of Delegates to which the resolutions will be presented for action.

Provided, that where a resolution has been first submitted to the Committee on Rules and Order of Business together with a written statement setting forth the reasons why said resolution was not mailed to the Executive Director more than 45 days prior to the meeting of the House of Delegates and also setting forth in said written statement the reasons why said resolution is of such an emergency nature that it cannot wait until the next meeting of the House, and that said Committee on Rules and Order of Business has approved said resolution for submission to the House, and that each delegate shall be furnished a copy before the next meeting of the House, then this subsection of the By-laws may be suspended with respect to said resolution upon a two-thirds vote of the House of Delegates.

Section 8—Reference Committees and Committee on Rules and Order of Business

A. Reference Committees

Immediately after the organization of the House of Delegates at each Annual Convention, the President shall announce the membership of the reference committees to serve during the convention for which they are appointed. Appointments to these reference committees shall be made by the Speaker with the assistance of the President. The chairman of each committee shall also be appointed by the Speaker with the assistance of the President and they shall also appoint such additional House committees as the House may approve. All committees hereunder shall serve only during the convention at which they are appointed. Appointments shall be made in time for them to be published in THE JOURNAL and the Handbook prior to such Annual Convention.

The Speaker with the assistance of the President shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of at least five members, three of whom including the chairman shall be delegate-members of the House, unless otherwise provided. To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except matters as properly come before the Board, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

B. Responsibilities of Reference Committees

Four or more Reference Committees designated by numerals are hereby constituted to which all matters shall be referred, at least one of which shall be organized for the sole purpose of studying the addresses of the president; president-elect; report of the Executive Director; and chairman of the Board of Trustees. This committee shall be mandated to translate recommendations made by these officers through resolutions for presentation to the House.

Where a report, resolution, measure, or proposition deals with more than one subject matter, reference thereof may, in the discretion of the Speaker of the House, be made (a) to as many reference committees as are necessary to cover all subjects included therein; or (b) to only one reference committee which the Speaker deems has within the scope of its reference the most important part of the matter referred.

No report of any reference committee shall be rejected on the ground that it covers something not included in the matters which such committee was created to consider.

C. Time and Place of Meetings

The time and place of meetings of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

D. Committee on Rules and Order of Business

The Committee on Rules and Order of Business shall be composed of the chairmen of the various Reference Committees appointed by the Speaker.

Section 9—Election of Officers

The officers of this Association with the exception of the Executive Director shall be elected by the House of Delegates as the first order of business at the final meeting of the House of Delegates, and no person shall be elected to any such office who has not been an active member of the Association for the preceding two years.

The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.

The officers, except the Executive Director shall be elected annually. All officers shall serve until their successors are elected and installed.

A. Method of Election

All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

B. Terms

The President, President-elect, Speaker, Vice-speaker, Treasurer and Assistant Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect, Treasurer and Assistant Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates.

C. Oath

The officers of the Association shall be installed by taking the following oath of office to be administered by the outgoing President of the Association at the final meeting of the House of Delegates:

I, _____, solemnly swear that I shall carry out to the best of my ability, the duties of the

office of the Indiana State Medical Association to which I have been elected.

I shall strive constantly to maintain the ethics of the medical profession and to promote the public health and welfare. I shall dedicate myself and my office to improving the health standards of the American people and to do the task of bringing increasingly improved medical care within the reach of every citizen.

I shall uphold the Constitution of the United States of America and of the State of Indiana, the Constitution and Bylaws of the American Medical Association and the Constitution and Bylaws of the Indiana State Medical Association at all times.

I shall champion the cause of freedom in medical practice and freedom for all my fellow Americans. To these duties and obligations, I pledge myself, so help me God.

CHAPTER VI—OFFICERS

Section 1—Composition

The officers of this Association shall be a President, a President-Elect, the Immediate Past President, an Executive Director, a Treasurer, an Assistant Treasurer, a Speaker, a Vice-Speaker, each of whom shall be a member, except the Executive Director, who need not necessarily be either a physician or a member.

Section 2—Removal, Death, Resignation, Vacancy

Any officer may be removed from office after a hearing before the Board, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Board.

In the event of the death, resignation, removal, or disability of the President, the President-Elect shall succeed to the presidency. In the event of the death, resignation, removal, or disability of both the President and the President-Elect, the Chairman of the Board shall become President Pro Tem and shall perform the duties and obligations as set forth in Section 3 of this chapter. As President Pro Tem the Chairman of the Board shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-Elect shall be elected, both of whom shall take office immediately upon their election.

The Board shall fill a vacancy in the office of Treasurer or Assistant Treasurer by an election by the Trustees at the next regular meeting of the Board following the occurrence of such vacancy.

Section 3—Duties

A. President

The President, or a member designated by him shall preside at all general meetings of the Association. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Trustees in building up the county societies and in making their work more practical and useful.

B. President-elect

The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties. Ex officio, he shall be a member of all commissions and committees.

C. Treasurer

The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Board. He shall receive all bequests and donations to the Association and shall demand and receive all funds due the Association except accounts due THE JOURNAL in the conduct of its business. The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the chairman of the Board. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

D. Assistant Treasurer

The Assistant Treasurer shall give bond at the expense of the Association in such amount as shall be required by the Board unless he is included in the coverage of a blanket or position bond. In case of death, or incapacity of the Treasurer, he shall succeed to all the duties and rights of the Treasurer until a new Treasurer be elected. In the absence of the Treasurer, he shall attend to the duties and rights of the Treasurer during such absence and he shall also perform such duties of the Treasurer as may be delegated and assigned to him by the Treasurer.

E. Executive Director

The Executive Director shall be the directing manager of the Association's headquarters and JOURNAL offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Board, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to nonprofessional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Board, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Board.

F. Speaker

The Speaker shall preside at all meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He may address the House of Delegates at the opening meeting of all conventions, limiting his address to matters of conduct and procedure in the House. He is entitled to vote when the vote is by ballot. In all other cases, he shall have the right to vote only in case of a tie.

He shall be elected annually from the membership of the House. Ex officio, the Speaker shall be a member of all Commissions and Committees and the Board of Trustees of this Association without the power to vote. Training in parliamentary procedure shall be mandatory for the Speaker and shall be provided at the expense of the Association.

G. Vice Speaker

The Vice Speaker of the House of Delegates shall officiate at meetings in the absence of the Speaker or at the request of the Speaker. The Vice Speaker shall be elected annually from the membership of the House.

Ex officio, he shall be a member of all Commissions and Committees and the Board of Trustees of this Association without the power to vote. Training in parliamentary procedure shall be mandatory for the Vice Speaker and shall be provided at the expense of the Association. In the case of death, resignation or removal of the Speaker, the Vice-Speaker shall officiate during the unexpired term.

H. Expenses

The necessary expenses of the above officers incurred in the line of duty herein imposed shall be allowed for in the budget, but excepting the Executive Director, this shall not include the expenses of attending the Annual Convention.

Section 1—Composition/Voting Power

The Board of Trustees shall consist of (1) the Trustees with power to vote and their duly elected alternates, each of the latter without power to vote except when the Trustee is not in attendance; and (2) ex officio, the President, President-Elect, Treasurer, Immediate Past President with power to vote, Assistant Treasurer without power to vote except in case the Treasurer is not in attendance, and the Speaker, [and] Vice-Speaker, and Executive Director without power to vote.

Section 2—Authority

The Board shall be the executive body of the Association, with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require, and perform and exercise all of the rights and duties as specified in this chapter.

Section 3—Election

Election—Trustee and Alternate. The Trustees shall be elected by the respective district societies. If any district fails to meet and elect its Trustee(s) or Alternate Trustee(s) by the time of the expiration of the incumbent's term of office, the Executive Director of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

Section 4—Meetings and Terms

The Board shall meet as follows: 1. The Board shall meet at least once each quarter of the calendar year, the time, date and location to be fixed by the Board. 2. On the day preceding the first day for the scientific meetings of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the chairman, or on petition of three Trustees. It shall hold no meeting that will conflict with any meeting of the House of Delegates. Notice of each regular meeting shall be given at least ten days before such meeting.

Special meetings may be called at any time by the Chairman or at the request of seven members of the Board. Notice shall be given at least five days before each special meeting. The notice shall specify the general purpose of and business to be transacted at the meeting.

It shall elect a chairman, and a clerk, who, in the absence of the Executive Director of the Association, shall keep a record of its proceedings. It shall, through its chairman, make an annual report to the House of Delegates. It shall organize itself at the meeting following the final session of the House of Delegates by electing its chairman who shall serve for one year. The chairman of the Board shall be elected by secret ballot. The number of terms of the chairman shall be limited to not more than three in succession.

Terms of Trustees shall begin with the first meeting of the Board following the final session of the House

of Delegates at the Annual Session.

The term of the elected Trustees shall be for three years and approximately one third of the number shall be elected annually. No Trustee shall be eligible to serve longer than two consecutive three-year terms.

Each Trustee district shall elect an Alternate Trustee whose term of office shall be for three years. The Alternate Trustee shall be elected in a year during which his Trustee is not elected. No alternate trustee shall be eligible to serve longer than two (2) consecutive three-year terms. The time given to serving an unexpired term shall not be considered in determining the period within which a trustee or alternate trustee may serve consecutively.

Section 5—Vacancies

In the event of a vacancy occurring from any cause, except expiration of the term of office, in the office of any District Trustee, the duly elected Alternate Trustee from the same district shall succeed to the office of the Trustee in that District for the unexpired term of said Trustee. In the event vacancies occur in any Trustee District in the offices of both Trustee and Alternate Trustee, the vacancies shall be filled by an election by the members of the Association within the Trustee District in which the vacancies occur. A call for such elections shall be issued by the Executive Director of the State Association following a conference(s) with the officers of the District organization. The call shall state the time and place of holding the election and shall be sent registered mail to the County Secretary as filed in the State Director's Office of each component society within the District. Such call shall be mailed within ten days after the State Director has learned of the vacancies. The election may be held at a special or regular meeting at which business other than the election may be transacted. Such election shall be held within fifteen days after the Director of the State Association shall have mailed such call.

Section 6—Organization and Duties

A. Immediately following the conclusion of the annual convention, the Board shall organize by electing a Chairman and a Clerk. The Chairman of the Board of Trustees shall be an ex officio member of all ISMA standing commissions and committees.

The Board of Trustees at its organization meeting, by resolution adopted by a majority of the Trustees in office, may designate two Trustees or members of the Association to complete the Executive Committee. Members of the Committee shall serve until the next organization meeting of the Board and until their successors are elected and qualified. The Executive Committee shall have such powers and duties as may be defined from time to time by resolution of the Board of Trustees.

B. Quorum

Twelve members of the Board shall constitute a quorum.

C. Attendance at Meetings

If any elected Trustee fails, without reason acceptable to the Board, in any one calendar year to attend a majority of the meetings of the Board, he shall thereby cease to be a Trustee, and the Executive Director shall thereupon take action in accordance with Section 5, Vacancies.

D. Meeting Notices

Notice is given if delivered in person, by telephone, mail or telegram. If mailed, such notice shall be deemed to be delivered when deposited in the United States mail, addressed to a Trustee (and other persons entitled to notice) at his address then appearing on the records of the Association, with postage prepaid, and if given

by telegraph, shall be deemed delivered when the telegram is delivered to the telegraph company.

Notice of any meeting and the object or business to be transacted at a meeting of the Board need not be given if waived in writing, or by telegraph, cable, or wireless before, during, or after such meeting. Attendance at any meeting shall constitute a waiver of notice of such meeting except where attendance is for the express purpose of objecting to the transacting of any business because the meeting is not lawfully called or convened.

E. Business of Association

The Board shall perform all acts and transact all business for or on behalf of the Association and manage the property and conduct the affairs, work and activities of the Association, except as may be otherwise provided in the Constitution or the Bylaws. All resolutions and recommendations of the House of Delegates including the expenditure of funds passed by the House of Delegates, shall be referred to the Board of Trustees which shall determine if the resolutions, recommendations or the expenditures are advisable. If it is decided that the resolution(s), recommendation(s), or the expenditure(s) is inadvisable, the Board shall report, at its earliest convenience, to the House of Delegates the reasons for its action.

F. Journal and Other Publications

The Board shall provide for the publication of and determine the editorial policies, in accordance with the policy enunciated by the House of Delegates, of (1) THE JOURNAL of the State Association, (2) publications as it may deem expedient, (3) a publication for public information and dissemination and (4) all proceedings, transactions and memoirs.

The Board shall provide for and superintend all publications of the Association, and shall appoint an editor and an editorial board, as it deems necessary, and fix the amount of their salaries. The proceedings of the Board for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of THE JOURNAL which immediately precedes the Annual Convention.

Appoint an editor or editors for all of the Association's publications.

G. Employ Executive

Employ the Executive Director, and fill any vacancy therein, who shall be the person to manage and direct the activities of the Association under the authority granted by the Board.

H. Financial Reports

(1) Have the accounts of the Association audited at least annually.

(2) Make proper financial reports concerning Association affairs to the House at its annual convention.

I. County Visitations, Expenses and Reports

Each Trustee shall be organizer, peacemaker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of THE JOURNAL which is issued immediately preceding the Annual Convention. The House of Delegates may take such action, if any, as it deems appropriate upon such reports. The necessary expenses incurred by such Trustee in the line of the duties herein imposed may be allowed by the Board on a properly itemized statement, but this shall not be construed to include

his expense in attending the Annual Convention of the Association.

J. Organizing County Societies

The Board shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly relations among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

K. Scientific Work

The Board shall, through its officers and otherwise, given diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

The Board shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

L. Interests of the Profession

The Board shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

M. Charters

The Board shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and Bylaws.

N. Board of Censors

The Board shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Board without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Trustee, and its decision in all such matters shall be final.

O. Election of At-Large Members to Executive Committee

The Board shall at its meeting following the close of the House of Delegates specify the duties and elect two members of the Association, at large, or of the Board, who, with the President, the President-elect, the Immediate Past President, the Treasurer, and the Chairman of the Board, shall constitute and be known as the Executive Committee. If such members of the Executive Committee be not members of the Board they shall not have the power to vote in the Board.

P. Duties of Alternate Trustee

The duties of the Alternate Trustee shall be:

(a) To represent the Trustee District when the regularly elected Trustee is not in attendance.

(b) To vote only when the Trustee is not in attendance either in the House of Delegates or in the Board meetings where he represents the regularly elected Trustee.

CHAPTER VIII—THE EXECUTIVE COMMITTEE

Section 1—Composition

The Executive Committee, constituted as provided in Chapter VII (O) of these Bylaws, shall hold its first meeting immediately following the meeting of the Board held at the close of the last meeting of the House of Delegates in the Annual Convention, and shall organize by electing its chairman. If the Executive Committee is unable to select a chairman within thirty (30) days after the final meeting of the House of Delegates, then a meeting of the Board of Trustees shall be called and a chairman of the Executive Committee shall be selected by the Board of Trustees. Its secretary shall be the Executive Director of the Association. It shall meet with the Executive Director on the call of the chairman, or of any three members, to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Director's office and such other duties as the Board may specify. It shall have all jurisdiction with respect to medical defense activities of the Association, and shall be governed by the rules it adopts concerning that activity and by the Bylaws of this Association. It shall make decisions for the Association, including matters pertaining to THE JOURNAL, during the intervals between the meetings of the Board, and shall report its actions to the Board.

Section 2—Budget Responsibility

It shall prepare a budget for the ensuing fiscal year; and all expenditures of the Association, except those otherwise provided for under the Constitution and Bylaws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and Bylaws shall be incurred by any officer, commission or committee. A committee, commission or officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

Section 3—Investment of Surplus Funds

The investment of all surplus funds of this Association shall be under the direct control and management of the Executive Committee subject to instructions in regard thereto which may be given by the Board at its option. The Executive Committee shall have the right and is encouraged to obtain the advice and counsel of the investment departments of any bank or trust company of Indianapolis in regard to the discharge of the duties covered by this chapter of the Bylaws.

Section 4—Student Loans

The Executive Committee shall have the authority to make loans to medical students in accordance with the terms and conditions under which funds are made available for that purpose. Rules and regulations adopted shall be subject to the approval of the Board. The Executive Director shall have the duty and responsibility of keeping minutes of all transactions and shall file a copy of such minutes, as well as a copy of all papers pertaining to any application or loans, in the Headquarters Office of the Association.

Section 5—Vacancy

A vacancy on the Executive Committee shall be filled

by an election by the Trustees at the next regular meeting of the Board following the occurrence of such vacancy.

CHAPTER IX—ORGANIZATION OF ACTIVITIES AND RESPONSIBILITIES

Section 1—Creation of Committees and Commissions

The organization of the Association, the performance of which is not provided elsewhere in the Constitution or Bylaws, and is not carried on in the meetings of the Board or of the House of Delegates, or by special committees created by the Executive Committee, the Board or the House of Delegates, may be performed by the following committees and commissions:

The Grievance Committee

The Future Planning Committee

The Medical Legal Committee

The Commissions are as follows:

COMMISSION ON MEDICAL SERVICES

This Commission encompasses the fields of:

Emergency Medical Services

Aging

Public Health

Governmental Medical Service Programs

Voluntary Health Agencies

Sports and Medicine

Medical Economics and Insurance

COMMISSION ON MEDICAL EDUCATION

This Commission encompasses the fields of:

Licensure

Accreditation

Education Program

COMMISSION ON LEGISLATION

This Commission encompasses the fields of:

State Legislation

Federal Legislation

COMMISSION ON CONSTITUTION AND BYLAWS

COMMISSION ON PUBLIC RELATIONS

This Commission encompasses the fields of:

Public Information

Special Activities

Interprofessional Relations

COMMISSION ON CONVENTION

ARRANGEMENTS

This Commission encompasses the fields of:

Specialty Medicine

Section 2—Committee Structure

Except as otherwise stated in the Bylaws, with specific reference to Chapter V, Section 8A, a Committee shall consist of not less than 4 nor more than 5 members, appointed from the general membership of the Association and shall be appointed annually by the President. The President shall also appoint the Chairman of each Committee. The committee chairman shall appoint a vice chairman.

Section 3—Commission Structure

Each Commission will consist of 15 members appointed by the President, with at least one member from each Trustee district. The original appointees in each commission shall be divided into three groups by lot. The first group shall serve three years; the second, two years; and the third, one year. Thereafter, each incoming President shall appoint five members of each commission to fill the vacancies resulting from the expiration of the terms of members, and such appointments shall be for three years. The President shall also appoint members to fill the unexpired term where any vacancy occurs through death, resignation or otherwise. The President shall appoint the chairman of each commission. The commission chairman shall appoint a vice chairman.

Section 4—Removal of Members

The President shall have the power, with the approval of the Board, to remove any member of any committee or commission where such member, for any reason, does not or cannot work at attempting to perform the duties pertaining to membership on such committee or commission.

Section 5—Terms

Unless otherwise provided in these Bylaws, no member of either a committee or a commission shall serve on the same committee or a commission more than two consecutive terms, but this shall not prevent his serving more than two terms if the term of another member intervenes. The time given to the serving of an unexpired term shall not be considered in determining the period within which a member may serve consecutively.

Section 6—Initial Meeting

Within sixty days after the meeting of the State Convention, the President will call all commissions and committees into a joint meeting in which he will give a statement of the duties and responsibilities of all committees and commissions, call special attention to any immediate problems confronting the Association, and assign such problems or parts thereof to appropriate committees and commissions. In these meetings the commissions may provide for such subcommissions within the separate commissions as they may deem advisable. Each committee or commission shall have the right to call upon other committees, commissions or members of the profession for counsel and advice with respect to its work.

Section 7—Coordination of Activities

Each committee and commission shall have the privilege and is encouraged to have joint meetings with any like committee or commission of the Auxiliary where such like committee or commission exists, for the purpose of coordinating their activities to make them more effective in the medical service of the public and the intent of the Association.

Section 8—Duties and Responsibilities

Each committee and commission shall have the duty and responsibility of keeping constantly and currently informed on the matters within the area of its special interest and activity; of studying the conditions within that area with the purpose of finding possibilities of improvement; of finding the best solutions it can to the specific problems referred to it; of contributing in its area to the achievements of the Association as a whole in the protection and improvement of the health of the whole human family and finally of making all its efforts useful by passing on to the Association in the most effective manner possible the results of its studies and activities in its own area of special interests.

A. The Grievance Committee

—The duties of this committee shall be to receive complaints, appeals or suggestions from physicians or laymen concerning professional conduct. It shall attempt to find the facts regarding any matter brought to its attention, through procedures proper and appropriate to that end, and shall attempt to adjust differences between patients and physicians, and between physicians. It may, if it believes the facts justify such action, cite a member of the Association to the Board of the State Association. It shall, subject to the approval of the Board, draw up a set of rules and regulations governing its procedure and official action.

B. The Future Planning Committee

—The function of this committee shall be to study and anticipate future trends and to stimulate the various

commissions in coordinated directions so there is concord to the entire operation of Indiana State Medical Association. It is not contemplated that it be an operational committee.

C. The Medical-Legal Review Committee

—The Medical-Legal Review Committee shall consist of three members selected from the Indiana State Medical Association whose duty it shall be to meet in joint session and work with a similar committee of three members of the State Bar Association to be appointed by the Indiana State Bar Association. These three members of the Medical Association shall function as the medical representatives provided for in the Joint Inter-Professional Code of the State Medical Association and the State Bar Association to carry out the purposes of that Code. Its duties shall be as stated in that Code in the form in effect from time to time as approved by the Association, and in all other medical-legal matters.

D. The Commission on Medical Services

—The Commission on Medical Services shall concern itself and assume special responsibility in obtaining information and giving counsel and advice to the Association with respect to all matters in which medical service comes into contact with any existing or proposed functions of government, including civil defense, rehabilitation of persons handicapped by abnormality or disease, medical service in welfare departments, maternal and child health programs sponsored through governmental agencies, medical care of military manpower, plans and programs for medical care of veterans, medical care for dependents of those in uniformed services of the government, plans and programs of the government for medical care now existing or which may hereafter be adopted by any special group, government programs for elimination of venereal disease and other communicable diseases, and all programs and plans for medical care to be provided through municipal, state or federal governments.

E. The Commission on Medical Education

—The Commission on Medical Education shall maintain liaison with, and try to be of assistance to, medical schools and the licensing board; and shall keep in contact with, and endeavor to assist in improving, undergraduate education, postgraduate education, intern training, resident training, preceptor instruction, and public school health education.

F. The Commission on Legislation

—The Commission on Legislation shall study all legislation, both state and national, and all local legislative trends and movements, as to their effect upon the practice of medicine and the protection of the public health; shall keep the profession informed at all times concerning the matters within its area of responsibility; shall conduct investigations of legislative proposals; and shall maintain liaison with members of the State Legislature and the United States Congress, and with the legislative activities of the American Medical Association. It shall strive to implement and make effective the legislative proposals adopted by the Association.

G. The Commission on Constitution and Bylaws

—The Commission on Constitution and Bylaws shall keep in contact with the developments and changes in procedures in carrying on the work of this Association; shall suggest revisions necessary to keep the Constitution and Bylaws always in accord with the practices and procedures best adapted to the functioning of the Association; and shall keep the practices and procedures of the Association consistent with the provisions from time to time contained in the Constitution and Bylaws—to the end that all members of the profession, by reference to the Constitution and Bylaws, may be able to obtain accu-

rate information regarding procedure and practice within the Association, and that hampering of such procedure and practice by obsolete provisions in the Constitution and Bylaws may be avoided.

H. The Commission on Public Relations

—The Commission on Public Relations shall collect and organize for dissemination to the public all matters of public interest within the field of medicine, including the activities of other commissions in which the public interest would be involved, and including also the achievements in the advancement of medicine which would be of interest to the public; shall disseminate all such information through the use of whatever media the commission may find adaptable to that purpose so that such information may be brought to the public in the most effective and convincing manner; and shall develop and maintain the relations of the medical profession with the public in such a way as to give the lay public a better knowledge and understanding of the aims, objects and value of the profession to the public.

I. The Commission on Convention Arrangements

—The Commission on Convention Arrangements, with the advice and assistance of the Executive Director, shall provide suitable accommodations for meetings of the Association, including the House of Delegates, Board, and of their respective committees, the scientific and technical exhibits, and in conjunction with the Executive Director, shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the Executive Director of the Association for publication in THE JOURNAL and in the official program, and shall make additional announcements during the session as occasion may require. The arrangements and the character of any and all technical exhibits must meet with the approval of the Executive Committee of the Association.

—It shall, with the approval of the Executive Committee, prepare a program for scientific work for the Annual Convention in which shall be included the respective programs for section meetings which shall be prepared through cooperation with the officers of the various sections; and it shall, with the approval of the Executive Committee, arrange for scientific exhibits as a part of the Annual Convention.

—The general, scientific and sectional programs, and the financial arrangements to provide for them must be approved by the Executive Committee before being officially announced.

Section 9—Ex Officio Members

The President, President-elect, Executive Director, Speaker and Vice-Speaker of the House shall be ex officio members of all the foregoing committees and commissions without voting rights where their inclusion on the committee or commission is not otherwise provided for in these Bylaws.

CHAPTER X—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of reelection.

CHAPTER XI—REFERENDUM

Section 1—Procedure

A general meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House

of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

CHAPTER XII—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

DIVISION FOUR— COUNTY AND DISTRICT SOCIETIES

CHAPTER XIII—COUNTY SOCIETIES

Section 1—Charters

—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws, shall, on application receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of said component society to conduct itself in harmony with the letter and spirit of this Constitution and Bylaws and other rules and resolutions of this Association.

—Charters shall be issued only upon approval of the Board and shall be signed by the President and Executive Director of this Association. The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

—Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Trustee for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Board, which shall decide what action shall be taken.

Section 2—Membership Qualifications

—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who holds a degree of Doctor of Medicine, a degree of Bachelor of Medicine or who holds a valid, unrestricted license to practice medicine and surgery, and who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be eligible for membership. Provided, however, that each county society may deny membership in such society for infraction or violation of any law relating to the practice of medicine or of the Constitution and Bylaws of such society, the Constitution and Bylaws of the Indiana State Medical Association or for a violation of the Principles of Medical Ethics of the Indiana State Medical Association; and may, after due notice and hearing, censor, suspend or expel any member for any such infraction. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Section 3—Right of Appeal

—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Board, and its decision shall be final.

—In hearing appeals the Board may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Trustees in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Section 4—Membership Transfer

—When a member in good standing in a component society moves to another county in this state, his name shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the transfer is proposed.

—A physician who has the major part of his practice in a county other than the county in which he resides may hold his membership in the county society of his residence or in the county society of the county in which he has the major part of his practice. However, no physician shall hold active membership in more than one county society at the same time.

Section 5—Direction of Profession

—Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Section 6—Selection of Delegates

—At the annual business meeting for election of other officers, in advance of the Annual Convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Director of this Association annually on or before February 1.

Section 7—Secretarial Duties

—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

The secretary of each component society shall prepare and send to the Trustee of his district a quarterly report briefly stating the activities of his county society including meetings, programs, changes in officers and personnel of membership. A copy of this quarterly report to the Trustee shall also be sent to the Executive Director of the State Association. The State Association shall supply each county secretary a form for these reports.

Section 8—Fiscal Year and Dues

—The fiscal year of the Association shall be from October 1 to September 30 of the succeeding year. The dues shall be collected by the calendar year and payable in advance.

Unless collected by the Indiana State Medical Association, the secretary of each component society shall forward the dues for his society to the Executive Director of this Association and shall furnish the State Association Headquarters with a roster of officers, members and a listing of non-affiliated physicians of the county, on or before January 1 of each year, and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive Director of this Association the dues for such members.

The dues and the rights and benefits of all members shall be as provided in Chapter I, Section I, et seq. of the bylaws.

Provided, however, that physicians elected to their first membership in this Association during the first six months of any year shall pay the regular annual dues for that year; and those elected to their first membership after July 1 of any one year shall pay fifty percent of the annual dues as dues for the remainder of that year. Interns and residents shall pay annual dues during their term of service in the hospital at a reduced rate established by the Board of Trustees.

In the event the county society relieves a member from the payment of dues on account of financial hardship, the secretary of the county medical society shall recommend in writing to the Trustee of his district the relief from State Association dues of said member of the society, showing why such recommendation should be granted. The Trustee in turn shall present the recommendation to the Board, which shall have the power to relieve a member of dues.

Section 9—Failure to Pay Dues

—Any county society which fails to pay its dues or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 10—Secretary Direction

—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues to the Association.

Section 11—Constitution and Bylaws

—Each component society shall have its own Constitution and Bylaws, which shall not be in conflict with the Constitution and Bylaws either of this Association or of the American Medical Association. An up-to-date copy thereof shall be filed with the Executive Director of the Indiana State Medical Association not later than May 1 of each calendar year, or where such copy is so on file and no change has been made, then it shall be sufficient to file a certificate to that effect with said Executive Director.

CHAPTER XIV—

TRUSTEE DISTRICT MEDICAL SOCIETIES

Section 1—Composition

—A Trustee District Medical Society, hereinafter called the district society, shall be a society whose members consist of the members of the county medical societies in the counties which constitute the Trustee district.

Section 2—Number of Districts

—The state shall be divided into thirteen (13) Trustee

districts with the boundary lines and numbers of each district to be as follows:

First District—Posey, Vanderburgh, Warrick, Spencer, Perry, Pike and Gibson Counties.

Second District—Knox, Daviess, Martin, Monroe, Owen, Greene and Sullivan Counties.

Third District—Dubois, Crawford, Harrison, Floyd, Clark, Scott, Washington, Orange and Lawrence Counties.

Fourth District—Jackson, Jennings, Jefferson, Switzerland, Ohio, Dearborn, Ripley, Decatur, Bartholomew and Brown Counties.

Fifth District—Clay, Vigo, Vermillion, Parke and Putnam Counties.

Sixth District—Shelby, Rush, Fayette, Franklin, Union, Wayne, Henry and Hancock Counties.

Seventh District—Morgan, Johnson, Marion and Hendricks Counties.

Eighth District—Madison, Delaware, Randolph, Jay and Blackford Counties.

Ninth District—Fountain, Montgomery, Boone, Hamilton, Tipton, Clinton, Tippecanoe, Warren, Benton, White, Newton and Jasper Counties.

Tenth District—Porter and Lake Counties.

Eleventh District—Carroll, Howard, Grant, Huntington, Wabash, Miami, and Cass Counties.

Twelfth District—Wells, Adams, Whitley, Allen, Noble, DeKalb, LaGrange and Steuben Counties.

Thirteenth District—Pulaski, Fulton, Kosciusko, Marshall, Starke, LaPorte, St. Joseph and Elkhart Counties.

Section 3—Constitution and Bylaws

—Each district society shall adopt a Constitution and Bylaws, which shall not conflict with the Constitution and Bylaws of the State Association, and only one district society shall exist within any one Trustee district. The authorized district society in each Trustee district shall receive a charter from the State Association, and the secretary of the district society shall have custody of the charter.

Section 4—Officers

—Each district society shall organize by electing a president, a secretary and a treasurer and Trustee(s) and Alternate Trustee(s) as the current Trustee(s) term and Alternate Trustee(s) term for the district expires, and such others as may be provided for in its Constitution and Bylaws. The office of secretary and treasurer may be held by the same physician. The Trustee(s) shall continue to have the same duties and terms as are set forth in the Constitution and Bylaws of this Association.

Section 5—Trustee Allocation

—Each district society shall have one Trustee and one Alternate Trustee for each 600 active members or major fraction thereof but in any event each district shall have one Trustee and one Alternate Trustee. The term of each trusteeship newly created by the numerical growth of a district shall begin at the organization meeting of the Board immediately following the adjournment of the second meeting of the House of Delegates at the next annual meeting, in accordance with Chapter VII, Section 6A.

Section 6—Dues

—The dues of the district society, in an amount fixed by the district society to meet the society needs, shall be collected by the secretaries of the component county societies, or by the Indiana State Medical Association and delivered to the treasurer of the district society. The secretary of each district society shall report to the office of the Indiana State Medical Association the names and addresses of the members of his district society, together

with a copy of the minutes of each meeting of his district society.

Section 7—Meetings

—Each district society shall meet at least once each year at a time and place to be fixed by the district society. On or before January 1 of each year each district society shall notify the headquarters of the State Association of the time and place of the annual district meeting for that year; but if no such notification has been received in the headquarters on or before the January meeting of the Board, the Trustee shall fix the time and place of the district meeting, and notice of such meeting shall be sent to the members of the county medical societies in such district.

Section 8—Notification to Headquarters

—Whenever a district society is to elect a Trustee and/or Alternate, the headquarters office of the State Association shall so notify the individual members of such district society not later than the first of March of the year in which the election is to occur.

—The district society shall send to the headquarters office of the State Association a copy of its program showing the time and place of its meetings, early enough that the headquarters office may notify all members within the district of the meeting at least thirty (30) days prior to the date thereof.

Section 9—Election to Blue Shield

—It shall be the duty of each district medical society to select in any manner it chooses a member from its district to serve a term or fill an unexpired term on the Board of Directors of Mutual Medical Insurance, Inc., (Blue Shield). Notice of such selection shall be immediately transmitted to the Board of Trustees of the Indiana State Medical Association which will officially place said selected member in nomination for election to said Board of Directors.

Any member selected or nominated to serve on the Board of Directors of Mutual Medical Insurance, Inc., (Blue Shield) may serve an unlimited number of three year terms as approved by his constituent county medical societies. The Board of Directors of Mutual Medical Insurance, Inc., (Blue Shield) should prepare a list of needed qualifications for nomination to this office.

DIVISION FIVE—MEDICAL DEFENSE CHAPTER XV—MEDICAL DEFENSE ADMINISTRATION, AUTHORITY AND PROCEDURES

Section 1—Dues Allocation

—One dollar and twenty-five cents (\$1.25) out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.

Section 2—Administration

—The administration of medical defense of this Association shall be intrusted to the Executive Committee, which shall constitute the Medical Defense Committee of the Association.

Section 3—Authority

—This committee shall have full authority governing all matters pertaining to this Chapter. In order to insure a fair and full presentation of defense for any member physician sued or against whom claim is made, the committee shall have the power to employ and pay an attorney of their choice as a consultant to the committee, and such other expenses as the committee may approve as necessary. It is expected that the committee's consultant attorney will provide necessary communication with the member-physician's personal attorney.

Section 4—Custodian of Funds

—The Treasurer of the Indiana State Medical Association shall be custodian of the defense fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and the chairman of the Board.

Section 5—Annual Report

—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money received and expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

Section 6—Liability

—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these Bylaws.

Section 7—Eligibility

—The Association shall not undertake the defense of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Director, shall be considered the only bona fide evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services, which are the basis of the suit, were rendered.

Section 8—Filing for Defense

—A member desiring to avail himself of the services of the Medical Defense Committee in connection with litigation brought or threatened must send to the Executive Director of the Association for an application blank. After completing the data concerning the case he shall submit to a local committee of his county medical society—to be composed of the president, secretary and one other member in good standing who may be nominated by the defendant—a full statement of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Section 9—County Society Committee

—The committee of the county medical society shall immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Medical Defense Committee of this Association.

Section 10—Appeal

—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the

Medical Defense Committee of this Association, whose decision shall be final.

Section 11—Deceased Member

—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Section 12—Locality Restrictions

—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Section 13—Adoption of Rules

—The Medical Defense Committee shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Section 14—Terms of Defense

—Medical defense as provided for by this Association shall be available to members under the terms stated in these Bylaws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

DIVISION SIX—MISCELLANEOUS

CHAPTER XVI—DIVISION OF FEES

This Association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership.

CHAPTER XVII—PARLIAMENTARY PROCEDURE

—The deliberations of this Association shall be governed by parliamentary usage as prescribed in the current edition of Sturgis Standard Code of Parliamentary Procedure, when not in conflict with this Constitution and Bylaws.

CHAPTER XVIII—AMENDMENTS

Section 1.—These Bylaws may be amended at any Annual Convention by a majority vote of all the delegates present at that convention. Amendments to the Bylaws must be submitted to the Commission on Constitution and Bylaws 30 days in advance of the Annual Convention. These amendments must be presented by the Commission on Constitution and Bylaws and are eligible for passage after lying on the table for one day. Any other Bylaw amendments presented to the House of Delegates at the time of the Annual Convention will not be eligible for consideration by the House of Delegates until the next annual meeting unless a two-thirds majority of the House votes to consider the amendment as presented.

Sec. 2.—Upon the adoption of this Constitution and Bylaws all previous Constitutions and Bylaws are hereby repealed.

CHAPTER XIX—MEDICAL ETHICS

The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

Principles of Medical Ethics of the American Medical Association

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to inter-

fere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the equality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Annual Report of Medical Licensing Board of Indiana

July 1, 1976, to June 30, 1977

ACTION: Filed.

This seven-member Board consists of five medical physicians, one osteopathic physician, and one chiropractic physician. The Board is charged with examining and licensing practitioners in several of the healing arts, including medicine, osteopathy, chiropractic, midwifery, physical therapy, physical therapy assistants, podiatry and, recently, physician assistants. In addition, the Board issues a physician's temporary permit for those who qualify for the FLEX examination. These permits are in effect until the next FLEX examination scores are in. The Board no longer issues registration for interns, but instead issues temporary medical permits for postgraduate students that include interns as well as residents. Medical, osteopathic, chiropractic and podiatry corporations are also verified by this Board.

This has been an eventful year for the Board. During the year the Board has moved into modern office space and with this came new furniture as well as a new filing system for most of its records. For the first time, the Board has appointed a fully licensed physician to be the executive director. This change was intended to improve our efficiency in disciplining our licensees.

The Board is required to hold two meetings a year: on the second Tuesday in January and on the second Tuesday in July. The work load has necessitated at least six official meetings a year that are scheduled and has found it necessary to call special Board meetings on demand. In the past fiscal year we held eight such meetings.

The Board has completed promulgating Rules and Regulations for Physician Assistants as well as for physicians. These Rules and Regulations are now with the Attorney General in the process of becoming law in the near future. The Board started to promulgate Rules and Regulations governing the chiropractic

art, but the court issued an injunction against the Board to await further word on these Rules and Regulations.

Within this Board there is a Podiatry Sub-Board consisting of two licensed podiatrists and three members of the Medical Licensing Board. This sub-Board holds two meetings annually and additional meetings as needed to transact other podiatry matters. The Podiatry Board holds two examinations a year, in the months of January and July. They also evaluate each application for licensure and make recommendations to the Medical Board.

The Physical Therapy Advisory Committee, which is composed of three licensed physical therapists appointed by the Governor, meets with the Medical Licensing Board and makes recommendations. They evaluate each application for physical therapist as well as for physical therapist's assistants for examination and/or for endorsement, and forward their findings and recommendations to the Board. They conduct three examinations each year, in the months of May, June and December.

Part of most of the Board meetings is taken up by hearings for licensees who have been accused of gross immorality, drug or alcohol addiction or other infractions of the laws laid down by Medical Act #1698.

Several types of fees are collected by the Board and then deposited in our General Fund. Fees for the practice of medicine, surgery, obstetrics or osteopathy are as follows:

Endorsement into the state\$200
FLEX examination 150
Endorsement to other states 50
Biennial renewal registration
(resident and non-resident) ... 40

Fees for Physician Assistants are in the process of being finalized. At the present time the Board does not have control of fees charged to other licensees.

Chiropractic fees are as follows:

Endorsement into the state\$100
Endorsement to other states 10
Biennial renewal registration
(resident and non-resident) ... 20

Podiatry fees are as follows:

Endorsement into the state\$ 50
Examination 25
(plus a \$10 filing fee)

Endorsement to other states 10
Biennial renewal registration 20

Physical Therapist and Physical Therapist's Assistants fees are as follows:

Endorsement into the state\$ 35
(plus a \$10 filing fee)
Examination 35
(plus a \$10 filing fee)

Endorsement to other states 10
Biennial renewal registration 20

Expired licenses will be reinstated when a \$50 penalty fee has been paid as well as the current fees for registration in all categories.

For foreign graduates who have qualified for a license, but do not have two years' postgraduate studies, the Board issues a preceptorship for a period to be determined by the Board but not to exceed two years, for a fee of \$200.

The Board administers the Federation of State Medical Boards Licensing Examination (FLEX), designed to test knowledge and ability of basic medical science, the clinical medical sciences and medical competence in the field of patient management. These examinations are held twice a year, in June and in December, each examination lasting three days.

The Board registers corporations for the healing arts and these at the present time cost \$10 plus a yearly renewal fee of \$10.

July 1, 1976—June 30, 1977

Applications received for December 1976, June 1977
State Board Examinations
(Med)1,771
Ineligible to take State Board Examination for various reasons 1
Approved for December 1976, June 1977 State Board Examinations1,340
Failed to appear for State Board Examinations 282
Applicants taking State Board Examinations1,058
Candidates failed the State Board Examinations 608
Candidates passed the State Board Examinations 450
Candidates from Indiana University Medical School taking State Board Examinations 266

			1974-1975	1975-1976	1976-1977
Candidates from Indiana University Medical School taking State Board and failed .	2	Applicants granted license in Indiana by endorsement/reciprocity (M.D.)	392	492	295
Candidates taking Doctor of Osteopathy Examination . .	3	Applicants endorsed to other states (M.D.)	321	314	263
Candidates taking Doctor of Osteopathy Examination, failed	1	Applicants granted license in Indiana by endorsement/reciprocity (Osteopathy)	10	22	26
Candidates from foreign medical and other schools taking State Board Examinations .	787	Applicants endorsed to other states (Osteopathy)	3	6	3
Candidates from foreign medical and other schools, failed	603	Applicants granted Physical Therapist's license in Indiana by endorsement/reciprocity	20	19	34
Candidates from foreign medical schools, passed	184	Physical Therapists endorsed to other states	23	15	33
Over-all failure rate	57.00%	Physical Therapist's Assistants endorsed to other states			2
I.U.M.S. graduate failure rate75%	Applicants granted Chiropractic license in Indiana by endorsement/reciprocity	9	23	36
Foreign medical school graduate, failure rate	77.00%	Chiropractors endorsed to other states	1	0	1
Candidates taking Physical Therapist Examinations . .	55	Applicants granted Podiatry license in Indiana by endorsement/reciprocity	2	27	2
Candidates taking Physical Therapists Examinations, failed	1	Podiatrists endorsed to other states	2	1	0
Candidates taking Physical Therapist's Assistants Examination	64	Licenses reinstated (all groups)	167	277	428
Candidates taking Physical Therapist's Assistants Examination, failed	9	Total Investigation (all categories)	58	87	111
Candidates taking Podiatry State Board Examination . .	0	Citations or Board action during the year (all groups)	15	23	15
Candidates taking Podiatry National Board Examination	22	Placed on probation (all groups)		4	1
Candidates taking Podiatry National Board Examination, licensed	22	Revocations during the year (all groups)	1	2	5
Candidates taking Podiatry National Board Examination, failed	0	Surrender of Narcotics privileges (Controlled substance, all groups)		4	4
		TOTALS, BOARD LICENSURE	1974-1975	1975-1976	1976-1977
		M.D. (resident and non-resident)	8,922	9,733	9,282
		D.O. (resident and non-resident)	311	345	353
		Drugless (resident and non-resident)	86	81	71
		Chiropractic (resident and non-resident)	363	386	422
		Physical Therapist	495	582	921
		Podiatrist	307	344	220
		Midwife	4	6	7
		Physical therapist's Assistant	68	99	161
		Temporary physical therapist permits issued	6	5	8
		Temporary medical permits issued	22	66	65
		Internship permits issued	162	171	44
		Temporary medical educational permits issued	57	41	15
		Temporary physicians permits issued	86	31	43
		Medical teaching permits issued	2	0	0
		Preceptorship licenses issued	82	31	18
		Medical corporations licensed in Indiana	961	1,115	1,325
		Chiropractic corporations licensed in Indiana	2	5	8
		Podiatry corporations licensed in Indiana	0	1	4
		Physical therapy corporations licensed in Indiana	1	1	1

FINANCIAL STATEMENT July 1, 1976—June 30, 1977

RECEIPTS BY QUIETUS		REFUNDS BY WARRANTS	BALANCE
Medical	\$406,476.50	\$3,335.00	\$403,131.50
Chiropractic	12,070.00		12,070.00
Podiatry	5,440.00		5,440.00
Physical Therapy	23,505.00		23,505.00
	<u>\$447,491.50</u>	<u>\$3,335.00</u>	<u>\$444,156.50</u>
TOTAL REVENUE			<u><u>\$444,156.50</u></u>

BUDGET MONEY	ALLOTMENT	DISBURSED	UNLIQUIDATED OBLIGATIONS	REVERTED TO GENERAL FUND
.1 Personal services	\$150,352.00	\$137,318.95		\$13,033.05
.2 Services other than personal	63,919.00	61,009.99		2,909.01
.3 Services by contract	29,775.00	27,619.44	\$1,495.85	659.71
.4 Materials, supplies, and parts	2,350.00	2,258.17		91.83
.5 Equipment	31,907.00	25,559.06	4,543.00	1,804.94
.8 In-state travel	16,126.00	16,049.62		76.38
.9 Out-of-state travel	1,452.00	687.92		764.08
	<u>\$295,881.00</u>	<u>\$270,503.15</u>	<u>\$6,038.85</u>	<u>\$19,339.00</u>

Resolutions

Resolution No. 77-1

Introduced by: Vanderburgh County Medical Society

Subject: ISMA DUES STATEMENT

ACTION: Not adopted.

Whereas, Dues statements for the county medical societies, Indiana State Medical Association, and the American Medical Association are combined into one statement which is sent out by the Indiana State Medical Association; and

Whereas, These statements list both the amount of dues for each organization, and several optional contributions for such programs as the Indiana Medical Political Action Committee, the Tel-Med program, etc.; and

Whereas, All the amounts for both dues and contributions, are added together into one total; and

Whereas, Many doctors, receiving such a statement, assume that the total figure is the amount which must be paid, not realizing that a portion of the total is optional; and

Whereas, This is an inappropriate and demeaning tactic which, in effect, Indiana physicians are misleading and manipulating themselves; now, therefore be it

Resolved, That ISMA modify the form of its dues statements so that dues are listed and totaled separately from voluntary contributions, and it is made clear which amount must be paid to maintain membership, and which amounts are optional.

Resolution No. 77-2

Introduced by: Clark County Medical Society

Subject: OPPOSITION TO NHI

ACTION: Substitute Resolution amended and adopted in lieu of Resolutions 77-2, 77-6, and 77-24.

Resolved, That the House of Delegates urge the AMA's active participation in the comprehensive health insurance debate; and be it further

Resolved, That the Indiana State Medical Association urge the AMA to continue to strive diligently to preserve private medical care and its financing by building upon the existing system of private health insurance, with minimum federal involvement; and be it further

Resolved, That this House of Delegates instruct the Board of Trustees of the Indiana State Medical Association to poll all ISMA members on whether or not they want the AMA to withdraw their bill for comprehensive health insurance

and vigorously oppose any AMA comprehensive health insurance bill; and be it further

Resolved, That Indiana ask all other state associations to do the same with their memberships; and be it further

Resolved, That if the polls reveal that the majority of physicians are of like mind, then prepare and submit a resolution to the AMA instructing the AMA to follow the dictates of its membership; and be it further

Resolved, That the AMA launch an immediate education campaign to educate all the American citizens concerning the issues of comprehensive health insurance.

FISCAL NOTE—Estimated cost \$1,900.00 (for ISMA poll)

Resolution No. 77-3

Introduced by: Fort Wayne-Allen County Medical Society

Subject: STUDY OF WITHHOLDING OF SERVICES

ACTION: Referred to Board of Trustees for report to the 1978 House of Delegates

Whereas, A recent nationwide American Medical Association survey indicated the majority of physicians in this country approve of withholding their services under certain selected circumstances in which third party decisions, i.e., private or governmental, impair the sound delivery of medical care for their patients; now, therefore be it

Resolved, That the Indiana State Medical Association undertake a study as to what its overall policy should be in such cases, and what the fiscal problems would be for those physicians and their families; and be it further

Resolved, That the results of this study be presented to the Indiana State Medical Association membership, along with specific recommendations and, further, that the Indiana State Medical Association membership be polled to determine their attitudes toward this matter.

FISCAL NOTE—\$5,000

Resolution No. 77-4

Introduced by: Steuben County Medical Society

Subject: WITHHOLDING OF SERVICES

ACTION: Referred to Board of Trustees for report to the 1978 House of Delegates

Whereas, There is a trend developing in third parties to control the health industry by regulating health insurance and hospitals and the activities within the hospitals; and

Whereas, There is a trend by third parties to organize physicians into HMO,

IPA, etc., and to encourage hospitals to provide total care including multispecialty outpatient care; and

Whereas, There is a trend to replace the traditional patient-physician relationship with the consumer-provider relationship; and

Whereas, A recent nationwide American Medical Association survey indicated the majority of physicians in this country approve of withholding their services under certain selected circumstances in which third party decisions, i.e., private or governmental, impair the sound delivery of medical care for their patients; now, therefore be it

Resolved, That the ISMA study the feasibility, effect and legality of the following:

1. The withholding of non-emergency physician services from a few selected hospitals with the purpose of negotiations with those hospitals to affect all hospitals.
2. The refusal to sign selected health insurance company forms by physicians.
3. The establishment of contracts between the medical staff and hospitals.
4. The establishment of a statewide withholding service fund to be made available if needed to physicians to meet their financial responsibilities, and be it further

Resolved, That the ISMA review the effect of the usual and customary program upon the patient-physician relationship and if indicated cause its reform or cancellation; and be it further

Resolved, That the results of this study be presented to the Indiana State Medical Association membership, along with specific recommendations, and further, that the Indiana State Medical Association membership be polled to determine their attitudes toward this matter.

FISCAL NOTE—\$5,000

Resolution No. 77-5

Introduced by: Fort Wayne-Allen County Medical Society

Subject: AMENDMENT OF THE BYLAWS OF THE ISMA TO PROVIDE FOR VETERANS ADMINISTRATION MEMBERSHIP

ACTION: Adopted.

Whereas, The new ISMA Bylaws provides for a category of members entitled "Military Service and Public Health Service Members" in Chapter 1, Section 3, Paragraph G; and

Whereas, There are other doctors living and practicing in other government agencies in hospitals in Indiana, namely the Veterans Administration, not provided for within the Bylaws; now, therefore be it

Resolved, That Chapter 1, Section 1 of the Bylaws be amended by adding "Veterans Administration Member" between "Military Service Member" and "Public Health Service Member"; and

Chapter 1, Section 3, Paragraph G be amended to include "Veterans Administration Member" so that this section would read "Military Service Members, Veterans Administration Members and Public Health Service Members. Any physician who is actively engaged in the military service, veterans administration or public health service should be eligible for membership in the Association with payment of regular dues; they shall receive THE JOURNAL."

Resolution No. 77-6

Introduced by: Huntington County Medical Society

Subject: COMPULSORY POLITICAL MEDICINE SPONSORED BY AMA

ACTION: Substitute resolution amended and adopted in lieu of Resolutions 77-6, 77-2, and 77-24 (See Resolution 77-2)

Resolution No. 77-7

Introduced by: Huntington County Medical Society

Subject: PSRO REPEAL

ACTION: Not adopted.

Whereas, The PSRO legislation was introduced and enacted primarily as a "cost controls" mechanism; and

Whereas, On Feb. 12, 1977, as reported in *Medical Economics* by Dr. Charles McSherry, head of the UR Committee at New York Hospital-Cornell Medical Center, that in reviewing 9500 charts, the average cost per ONE case found of overutilization was \$34,267, thereby revealing its counter-results; and

Whereas, PSRO "regulations" have already inflicted irrevocable, destructive, damaging results on Hospital-Board Members-Doctors-Patients Relationship; now, therefore, be it

Resolved, That the Indiana State Medical Association petition Congress to repeal PSRO; and, be it further

Resolved, That the Indiana State Medical Association send a copy of this resolution, if adopted, to all the State Medical Associations throughout the country.

Resolution No. 77-8

Introduced by: Huntington County Medical Society

Subject: TO PREVENT FINANCIAL AMA SUPPORT FOR DR. QUENTIN YOUNG

ACTION: Not adopted.

Whereas, The American Medical Association Board of Trustees has resolved to offer \$15,000.00 in defense of Quentin Young, M.D.; and

Whereas, The following observations, among others, are reported about Quentin Young, M.D.,

1. He was one of the founders and chairman of the "Medical Committee for Human Rights" which in part tried to spread the notion that "most doctors, especially those who were members of the AMA, were unconcerned about human rights."
2. His MCHR Organization paid for a full page ad in the *New York Times*, in 1968, that in part called for Compulsory Political Medicine.
3. The MCHR claimed credit for the Student Health Organization, an organization which "shouted for a North Vietnam victory," etc.
4. Is reported to have been a "sympathizer of the lawless communist dictatorship of Ho Chi Minh."
5. Is reported to be "one of Private Medicine's dedicated enemies."
6. Is reported to have appeared before the House Committee on un-American Activities, October 3rd and 4th, 1968, during the course of hearings on "Subversive involvement in disruption of the 1968 Democratic Party National Convention," and "when asked if he were a communist, he pleaded the FIRST, but not the FIFTH Amendment;" now therefore be it

Resolved, That the House of Delegates of the Indiana State Medical Association request the American Medical Association Board of Trustees to revoke forthwith the financial support offered to Quentin Young, M.D.; and be it further

Resolved, That the Indiana State Medical Association House of Delegates instruct ISMA to send a copy of this resolution, if adopted, to all the State Medical Associations in the U.S.A.

Resolution No. 77-9

Introduced by: Twelfth District Medical Association

Subject: LIMITATION ON HOLDING MAJOR OFFICES

ACTION: Referred to Future Planning Committee for further study.

Whereas, The strength of any organization depends on the broad base of able, willing workers and the concentration of decision making in too few individuals tends to limit new ideas and discourage many interested members; and

Whereas, The ISMA in recent years has seen a relative round-robin of major policy decision-making offices within a limited number of individuals; now, therefore, be it

Resolved, That the offices of president-elect, president, speaker of the House, vice-speaker of the House, AMA delegates, AMA alternate delegates, and Board of Trustee members be classified as major offices; and be it further

Resolved, That any individual may not hold more than one major position during a given term and he or she must resign from a major office if they attain a second; and be it further

Resolved, That the ISMA as a general policy encourage appointments that provide as broad a base as possible for its own and state appointed positions.

Resolution No. 77-10

Introduced by: Twelfth District Medical Association

Subject: PRIVILEGE OF DISCUSSION AT REFERENCE COMMITTEES

ACTION: Substitute Resolution 77-10 adopted.

Whereas, the reference committees of the Indiana State Medical Association are the only true forum for each individual ISMA member, and the committees represent the democratic base of the organization, and

Whereas, The reference committees have been attended in great number by non-members of the Association, and

Whereas, The advice from these people is sought, but may not be representative of the thought of the Association membership; therefore, be it

Resolved, That non-ISMA members may present technical or reference materials only with the approval of the reference committee which needs that information, and be it further

Resolved, That non-ISMA persons may register as guests and be at the call of the reference committee for testimony after which they may be excused from further attendance, and be it further

Resolved, That the matter be referred to the Commission on Constitution and Bylaws for implementation on conference with the speaker and vice-speaker of the House with particular reference to Section 8 of Chapter 5.

Resolution No. 77-11

Introduced by: Twelfth District Medical Association

Subject: EQUALIZATION OF MEDICAL CARE REIMBURSEMENT

ACTION: Adopted and referred to Board of Trustees

Whereas, The cost of health care has increased dramatically in recent years and many segments of society and government are demanding more efficient delivery of care; and

Whereas, Hospital delivery of medical

care has enjoyed special status with the insurance industry so that procedures done in the hospital by private or hospital employed physicians have been reimbursed at a rate above and beyond supplies, overhead, and labor costs; and

Whereas, Many surgical procedures, first aid treatments, and diagnostic procedures can be performed as an outpatient or office procedure and the reimbursement for these have usually been less than if they were hospital based and have rarely included physician overhead cost; now, therefore, be it

Resolved, That the ISMA support changes in the traditional hospital-insurance carrier relationship in order to equitably reduce health care cost; and be it further

Resolved, that the ISMA Board of Trustees should through the appropriate commission or commissions elicit the public's support for modifying existing regulation of the insurance industry to insure such changes.

Resolution No. 77-12

Introduced by: Board of Trustees, St. Joseph County Medical Society

Subject: ASSOCIATION OF AMERICAN MEDICAL ASSISTANTS, INC., INDIANA SOCIETY

ACTION: Adopted as amended.

Whereas, AAMA, INC., and its affiliated state and local chapters are comprised of employees of actively practicing physicians; and

Whereas, The purpose of the members of this organization is to serve the physician and the patient by furthering their education in the allied health field; and

Whereas, Their goals are established as truthfulness, helpfulness, integrity, sincerity and loyalty to the allied health field, physician and community; now, therefore, be it

Resolved, That physicians support the concepts and goals of AAMA, INC., and urge their employees to join and actively participate in this organization; and be it further

Resolved, That each district trustee or his designated representative attend any meeting or be an advisor for such chapters if so requested by AAMA, Inc.

Resolution No. 77-13

Introduced by: Board of Trustees, St. Joseph County Medical Society

Subject: TRAVEL AND HOUSING ALLOWANCE FOR COUNTY MEDICAL EXECUTIVES

ACTION: Not adopted.

Whereas, Some counties in certain instances have been forced to hire Medical Executives to manage the county medical society program at considerable expense to each physician; and

Whereas, The ISMA has requested that such Executives attend meetings in various parts of the state to establish an interchange of information to benefit members of the state and county societies; and

Whereas, This type of communication benefits the ISMA and its physician members; and

Whereas, These meetings partially alleviate the necessity of field representatives and thus a significant savings in manpower and associated travel expenses, and

Whereas, Travel and housing allowance is paid to physician members attending ISMA committee and Board meetings; now, therefore, be it

Resolved, That any professional County Medical Society Executive be reimbursed by ISMA for travel and housing expenses incurred during attendance at any meeting called by the ISMA other than the annual meeting and specifically for such Medical Executives.

FISCAL NOTE—\$1200.00

Resolution No. 77-14

Introduced by: Seventh District Medical Society

Subject: COMMISSION REPRESENTATION

ACTION: Tabled for 1978 House of Delegates.

Whereas, In 1968 the House of Delegates amended the Constitution and By-Laws of this Association to provide the addition of a Trustee and an Alternate Trustee, representation of Seventh District Medical Society members consistent with the District's relative size; and

Whereas, The Seventh District Medical Society membership continues to represent more than twenty percent of the total membership of this Association; and

Whereas, The Commissions of this Association are designed to provide member input to the deliberations of the Association; and

Whereas, The Constitution and By-Laws restrict the participation of Seventh District members as Presidential appointees to Commissions of the Association, thereby creating a distinct disparity in representation, similar to that which existed on the Board of Trustees prior to 1968; therefore be it

Resolved, That the By-Laws of the Indiana State Medical Association be amended by striking the first sentence of Section 3, Chapter IX, and inserting two sentences as follows: The President shall appoint one Commission member for each 600 active members or major frac-

tion thereof but in any event each District shall have one member on each Commission. Two additional members may be appointed at large without regard for District. Also amend by deletion of the word "five" from the fourth sentence, Section 3, Chapter IX.

Resolution No. 77-15

Introduced by: Marion County Medical Society

Subject: PROVIDING COPIES OF PATIENTS' HOSPITAL BILLS TO PHYSICIANS

Referred to: Board of Trustees

Whereas, The percentage of the Gross National Product used for health care is rising; and

Whereas, Physician fees are but a small percentage of this total; and

Whereas, Legislators and the public often tend to blame the rising costs totally on the physician; and

Whereas, Cost containment without sacrificing quality of care of freedom is necessary for the survival of the present pluralistic medical care delivery system; and

Whereas, Physicians order most of the care given to the hospitalized patient; therefore be it

Resolved, That the Indiana State Medical Association work with the Indiana Hospital Association and the medical staff of each hospital in an effort to provide each physician with a hospital bill of at least one of his admitted patients per month, the sample bill to be chosen on a random basis.

Resolution No. 77-16

Introduced by: Marion County Medical Society

Subject: CHILD HEALTH CARE
ACTION: Not Adopted. (Further reference: Report I, Board of Trustees)

Whereas, It is a goal of both the public and the Indiana State Medical Association that each individual within the country should have a personal physician who is the focus of coordinating all medical and medically related services for that individual; and

Whereas, In many areas of the country where there are adequate numbers of primary physicians, school districts are pursuing a multitude of disjointed organ-related screening programs; therefore be it

Resolved, That in areas not designated as underserved by the Department of Health, Education, and Welfare, the Indiana State Medical Association encourage local medical societies to oppose mass screenings of school children in fragmented organ system screening programs; and be it further

Resolved, That the Indiana State Medical Association encourage local societies to develop with the schools methods of referral so that each child can have a physician to carry out necessary periodic evaluations of the child as a whole, rather than have the child's care involved in fragmented, disjointed programs.

Resolution No. 77-17

Introduced by: Marion County Medical Society
Subject: MEDICAL COST
ACTION: Adopted.

Whereas, The cost of medical care has risen rapidly over the past decade, in part due to inflation, part due to new technologies, and in part due to increased utilization; and

Whereas, The actions of physicians play a well-defined role in determining many of these costs; and

Whereas, A well-defined research of the factors affecting the cost of health care are not widely known nor available; and

Whereas, Such research might aid medicine in addressing causes of rising medical costs and to refute the simplistic explanation of rising medical costs offered by medicine's detractors; therefore be it

Resolved, That the Indiana State Medical Association encourage implementation, distribution, publication, and broadcast of research, studies, and reports which address the complex combination of resources and their utilization which effect rises in cost of medical care.

Resolution No. 77-18

Introduced by: Marion County Medical Society
Subject: MATERNAL AND CHILD HEALTH CARE LEGISLATION
ACTION: Adopted.

Whereas, The Maternal and Child Health Care Act (HR 1702) and its companion bill, the National Health Insurance for Mothers and Children Act (S 370), advocate an entirely new system of health care for women and children of this country; and

Whereas, This legislation would by economic coercion force a substantial portion of these people to give up a system of medical care which they prefer; and

Whereas, This legislation encompasses fiscal strategies that would threaten the economic viability of the country; and

Whereas, This bill represents the first step on the road to total federalization of medical services; therefore be it

Resolved, That the Indiana State Medical Association vigorously oppose the

Maternal and Child Health Care Act (HR 1702) and the National Health Insurance for Mothers and Children Act (S 370), encourage all of its components to seek support for this position with their individual legislators, and seek the assistance of other organized segments of the population in this opposition.

Resolution No. 77-19

Introduced by: Marion County Medical Society
Subject: OPPOSITION TO HOSPITAL COST CONTAINMENT ACT OF 1977
ACTION: Adopted.

Whereas, The Hospital Cost Containment Act of 1977, which was introduced April 25, is designed to contain hospital costs and does not improve patient care services; and

Whereas, The increase in hospital costs can be directly attributed to increases in the minimum wage, hospital and professional liability insurance premiums, and the intensity of patient care in addition to the impact of a highly inflationary economy during the past decade; and

Whereas, Little federal government recognition or support has been given to the widespread cost containment activities promoted by hospitals which include shared medical, management, and supportive services; and

Whereas, The cost of the administration through a burgeoning bureaucracy of this proposal will negate the Act's projected savings; and

Whereas, The provisions of the legislation are patently discriminatory toward voluntary, nonprofit hospitals and will have the effect of converting privately owned and charitable hospitals into public utilities; therefore be it

Resolved, That the Hospital Cost Containment Act of 1977 is discriminatory and selective and is in effect the enactment of wage and price controls which will result in the rationing of health care to the people by either bankrupting hospitals or forcing them to curtail the quality and quantity of services; and be it further

Resolved, That the Indiana State Medical Association oppose this legislation.

Resolution No. 77-20

Introduced by: Marion County Medical Society
Subject: VOLUNTARY CONTINUING MEDICAL EDUCATION FOR ISMA MEMBERSHIP
ACTION: Adopted.

Whereas, In its scientific component the medical profession functions within

the most dynamic body of knowledge; and

Whereas, The appellation "professional" implies continued acquisition of knowledge relevant to the services performed; and

Whereas, The Indiana State Medical Association is recognized as the professional association of physicians in Indiana; therefore be it

Resolved, That the Indiana State Medical Association express its dedication to the continued acquisition of knowledge on the part of physicians by supporting a system of voluntary continuing medical education as opposed to a mandatory system of continuing medical education.

Resolution No. 77-21

Introduced by: Marion County Medical Society
Subject: HEALTH PROFESSIONS CONFIDENTIALITY
ACTION: Adopted.

Whereas, Privacy is supposedly the one remaining impenetrable castle of an individual; and

Whereas, The United States Government has officially passed legislation protecting confidentiality and

Whereas, The use of computer enables us to forever store any data obtained about any individual and man has never devised a foolproof system to protect any information; and

Whereas, The Health Professions Education Assistance Act of 1976 (PL 94-484) obviously invades the privacy of all physicians and dentists and may be extended later to other health professions personnel through the following provision:

"Sec. 708. (a) The Secretary shall establish a program including a uniform health professions data reporting system, to collect, compile, and analyze data respecting all physicians and dentists in the United States and its territories and possessions. The Secretary is authorized to expand the program to include, whenever he determines it necessary, the collection, compilation and analysis of data respecting pharmacists, optometrists, podiatrists, veterinarians, public health personnel, audiologists, speech pathologists, technologists, and any other health personnel in states designated by the Secretary to be included in the program. Such data shall include data respecting the training, licensure status (including permanent, temporary, partial, limited, or institutional), place or places of practice, professional specialty, practice characteristics, place and date of birth, sex, and socioeconomic background of health professions personnel and such other demographic in-

formation regarding health professions personnel as the Secretary may require."

therefore be it

Resolved, That the House of Delegates of the Indiana State Medical Association ask the elected representatives in Congress to seek alteration of Section 708 of PL 94-484, the Health Professions Education Assistance Act of 1976, which singles out physicians and dentists as one specific group for invasion of privacy.

Resolution No. 77-22

Introduced by: Marion County Medical Society

Subject: OPPOSITION TO MAN-
DATED MEDICAL
SCHOOL ADMISSIONS

ACTION: Adopted.

Whereas, The Health Professions Educational Assistance Act of 1976 (PL 94-484) contains as a requirement for any school of medicine to receive capitation grant support for its students, that the school must accept for advanced placement a student quota established by the Secretary of HEW for those U.S. citizens in foreign medical schools who have successfully completed at least two years in such schools and who have passed Part I of the National Boards without consideration of any other academic requirements for admission; and

Whereas, This provisions constitutes a precedent-setting direct Federal intervention in the selection for admissions process of schools of medicine and becomes, therefore, an historic intrusion on the academic freedom and independence of universities; and

Whereas, The academic freedom and independence of our society's universities and medical schools are fundamental to advancement in a free society; and

Whereas, The Health Professions Educational Assistance Act of 1976 as enacted will also punish the students in those schools of medicine which do not comply with the above requirement on grounds of academic freedom by denying students enrolled at such medical schools access to the new program of Federally Insured Health Professions loans for their education; and

Whereas, The net effect of this action for such schools who decline to participate will be to deny equal access to medical education to all socioeconomic groups in our Society; therefore be it

Resolved, That since the Health Professions Educational Assistance Act of 1976 (PL 94 484) intrudes on academic freedom and discriminates against students in the United States two-year medical schools in favor of U.S. citizens transferring from foreign medical schools by requiring the U.S. schools to give preference to these transferees as a con-

dition for receiving capitation grants, the Indiana State Medical Association should seek early amendments of the law to either:

1. delete the admissions requirement giving preference to U.S. citizens transferring from foreign medical schools,
2. convert the provision in question to a special project program to which each school could apply and comply as it saw fit, or
3. as a minimum, separate participation in the new Federally insured health professions student loan program from a school's compliance with these capitation requirements.

and be it further

Resolved, That the Indiana State Medical Association strongly support the Indiana University School of Medicine in its opposition to the restrictive aspects of PL 94-484 before the public and the Indiana General Assembly who must guarantee the financial support of the School necessary to oppose this law.

Resolution No. 77-23

Introduced by: Marion County Medical Society

Subject: UNETHICAL TO USE
LAETRILE

ACTION: Adopted Substitute Resolution 77-23

Resolved, That ISMA affirm the AMA position on laetrile which states that (1) laetrile is a substance that has no proven value as a drug; (2) There is a danger in delay of diagnosis and treatment of neoplastic diseases by methods not generally recognized by the medical profession as beneficial and effective, and (3) the use of laetrile exploits the victims of neoplastic disease and their families by preying on the emotions of the hopelessly ill and, in some cases, for the profit of the unscrupulous.

Resolution No. 77-24

Introduced by: Marion County Medical Society

Subject: ENDORSEMENT OF
AMA GUIDELINES
FOR COMPREHENSIVE HEALTH INSURANCE PROPOSALS

ACTION: Substitute resolution amended and adopted in lieu of Resolutions 77-24, 77-2, and 77-6 (See Resolution 77-2)

Resolution No. 77-25

Introduced by: Marion County Medical Society

Subject: ESTABLISHMENT OF
SECTION ON NEUROLOGICAL SURGERY

ACTION: Adopted.

Whereas, Neurosurgical care has become an integral part of medical care delivery system in Indiana and the nation; and

Whereas, The neurosurgeons of Indiana are concerned with the recruitment and retention of qualified neurosurgeons for the citizenry of Indiana; and

Whereas, The American Medical Association, recognizing the need to provide neurosurgical physicians a forum within the Federation, has established a Commission on Neurological Surgery; and

Whereas, The American Medical Association of Neurological Surgeons is an active national organization for neurosurgical physicians; therefore be it

Resolved, That the House of Delegates of the Indiana State Medical Association establish an official Section on Neurological Surgery of this Association.

Resolution No. 77-26

Introduced by: Ad Hoc Committee on the Impaired Physician

Subject: PERMANENT ISMA
COMMITTEE ON THE
IMPAIRED PHYSICIAN

ACTION: Adopted as amended and referred to the Commission on Constitution and Bylaws for implementation.

Whereas, The President of the Indiana State Medical Association determined there was a need for an Impaired Physician Program to recognize, treat and rehabilitate physicians who are impaired by neuropsychiatric illness, physical infirmities or alcohol and other drug dependence; and

Whereas, Because of this need and the fact that the districts are generally aware that the problem does exist and most are in favor of a workable program, the president appointed an ad hoc committee to develop a proposed action plan; now, therefore, be it

Resolved, That the Constitution and Bylaws of the Indiana State Medical Association be changed to include The Impaired Physician Committee as one of the standing committees of the Association; and, be it further

Resolved, That this committee be responsible for developing a program in cooperation with the Medical Licensing Board using the guidelines provided in the Medical Practice Act; and, be it further

Resolved, That this program include efforts to encourage an informal and formal referral of impaired physicians through county medical society screening committees.

Resolution No. 77-27

Introduced by: Vanderburgh County Medical Society
Subject: PARTICIPATION IN PROFESSIONAL STANDARDS REVIEW
ACTION: Adopted as amended.

Whereas, The House of Delegates of the Indiana State Medical Association has adopted a position opposing the federal professional standards review program on the basis that it is an unwarranted intrusion into the private practice of medicine; and

Whereas, The PSRO law nevertheless remains in effect; and

Whereas, The law gives physicians an initial opportunity to plan and operate the program in reference to non-medical individuals or groups; and

Whereas, Every PSRO area in Indiana now has a physician organization set up for the purpose of planning and carrying out professional standard review; and

Whereas, These bodies are now turning to the Indiana State Medical Association and to the county medical societies for help with various aspects of their programs; and

Whereas, Professional standards review cannot either protect the patient or avoid infringing on the medical profession unless it functions in close harmony with the profession; now, therefore, be it

Resolved, That the Indiana State Medical Association's philosophical objection to a government-funded program of professional standards review as an intrusion into the private practice of medicine, remains, and is not mitigated by the fact of physician participation in the PSRO program.

Resolution 77-28

Introduced by: Commission on Medical Services
Subject: PROVIDING ANNUAL REPORTS
ACTION: Not adopted.

Whereas, ISMA health providers could be better informed on medical economic matters concerning patient care; and

Whereas, Members and their dependents should be maximally informed on the utilization patterns of themselves as a group; and

Whereas, ISMA should be knowledgeable about the health of its members; now, therefore be it

Resolved, That ISMA should request that Blue Cross-Blue Shield issue to ISMA members copies of their annual reports, unless members wish not to receive them.

Resolution 77-29

Introduced by: Commission on Medical Services
Subject: DISCLOSURE OF PROFILE FOR PROCEDURES
ACTION: Not adopted.

Whereas, The consumer has difficulty in determining the true cost of the individual's medical care under usual and customary or non-assigned Medicare programs; and

Whereas, Even when physicians discuss the fee prior to service, the consumer cannot always obtain the usual and customary from the carrier; now, therefore be it

Resolved, Private carriers and government intermediaries be required to disclose to patients, on demand, the current profile for procedures contemplated.

Resolution 77-30

Introduced by: Commission on Medical Services
Subject: ELIMINATE REQUIREMENTS FOR DISCUSSION OF FEES
ACTION: Referred to Commission on Medical Services to be resubmitted.

Whereas, Without being a party to the negotiations or contract of the usual and customary policy, physicians are obliged to discuss their fees prior to rendering services or accept the assigned profile value (the remainder to be paid by the patient, they are told); now, therefore be it

Resolved, That, in order to resolve this impasse, legislation (state or federal) or regulations, if possible, be supported by ISMA to eliminate requirements for discussing fees in order to attain differential payments from patients.

FISCAL NOTE: Appropriated from Commission on Legislation budget

Resolution 77-31

Introduced by: Commission on Medical Services
Subject: UTILIZATION OF PHYSICIANS AT MEETINGS
ACTION: Amended and referred to the Board of Trustees

Whereas, Daytime meetings concerning health matters are increasing through the years; and

Whereas, Physician representation is desirable, if not imperative, at many meetings; and

Whereas, currently, staff serves well in a reporting role, but is less effective when entering discussions or stating ISMA policy than an adept M.D. in the same role; now, therefore be it

Resolved, That the ISMA budget for physicians to attend designated meetings when professional expertise is needed. The fees paid to such designated physicians should be determined by the Board of Trustees.

Resolution 77-32

Introduced by: Commission on Medical Services
Subject: REVIEW AND ADJUSTMENT OF FEE PROFILES
ACTION: Adopted and referred to Board of Trustees

Whereas, Insurance carriers are solely responsible for the data systems operations concerning usual and customary health insurance plans; and

Whereas, The medical profession, particularly ISMA, has had an historical and organized interest in this type of program; and

Whereas, Inflation factors in our economy necessitate frequent revisions of usual and customary profiles in order to make the program relevant and effective for beneficiaries; now, therefore be it

Resolved, That ISMA meet with appropriate labor and management groups to allow for proper insurance regulations or legislation (if necessary) to assure that fee profiles are reviewed and adjusted at least every six months by insurance companies doing business in Indiana.

Resolution 77-33

Introduced by: Commission on Medical Services
Subject: EMPLOYMENT OF DATA ANALYST
ACTION: Referred to Trustees for consideration. (Further reference: Report of the Commission on Medical Services; Resolution 77-48; Report S, Board of Trustees)

Whereas, Data systems for implementation of private and governmental medical programs are designed without input from organized medicine; and

Whereas, Organized medicine is not adequately informed about or concerned with design or programming of data systems; and

Whereas, Organized medicine does not have the capability of analyzing the performance of ongoing computer programs to ascertain whether they are accurate, efficient and meeting the goals of the program; now, therefore be it

Resolved, That the Indiana State Medical Association devise a job description for a data analyst on a part-time or consulting basis whose services would be available to officers, board, staff and research and development bodies such as

commissions and ad hoc committees concerned with non-ISMA data programs concerning the practice of medicine in Indiana, particularly a) Medicaid, b) private usual and customary programs, c) actuarial data concerning utilization of ISMA members' insurance plans, d) Medicare, and e) monitoring of proposed data systems such as Health Consortium, PSRO, HSA, etc.

FISCAL NOTE: \$25,000.00

Resolution 77-34

Introduced by: Commission on Medical Services

Subject: SUBMISSION OF INSURANCE PLANS

ACTION: Adopted and referred to the Board of Trustees

Whereas, The Commission on Medical Services has an ongoing interest and responsibility in the area of members' insurance plans; and

Whereas, The commission has not received adequate (or at times any) information concerning experience or proposals; now, therefore be it

Resolved, That all insurance plans for ISMA members be submitted to the Commission on Medical Services at least 90 days prior to the effective or renewal dates of the various plans.

Resolution 77-35

Introduced by: Commission on Medical Services

Subject: ESTABLISHMENT OF AN ISMA SELF-ADMINISTERED INSURANCE PLAN

ACTION: Referred to Board of Trustees.

Whereas, Inadequate information concerning members' utilization of ISMA health insurance policies has been available to the study and directive bodies of ISMA; and

Whereas, Medicare is blamed for the high cost of care; and

Whereas, Our carrier's claims are going up for high utilizers of health care, so that some members have more than one plan with our present carrier; now, therefore be it

Resolved, That ISMA attempt to establish an ISMA self-administered plan with our present carrier or any future carrier.

FISCAL NOTE: This plan would be financed by a percentage of the participants' premiums.

Resolution 77-36

Introduced by: Commission on Constitution and Bylaws

Subject: MEDICAL STUDENT COMPONENT SOCIETY

ACTION: Adopted and referred to Board of Trustees.

Whereas, In the proposed Bylaws of the Indiana State Medical Association it states, "Student members may be represented in the House of Delegates with the power to vote. They shall be entitled to send one delegate or one alternate." (See Division One—Membership, Section 3—Members by Category - I); and

Whereas, Should this portion of the revised Bylaws be adopted, there has been no system established for the election of the student delegate and/or alternate; and

Whereas, The Commission on Constitution and Bylaws recognizes a need for establishing a formal pattern of election of student representatives to the House of Delegates; now, therefore be it.

Resolved, That the House of Delegates endorse the study and possible formation of a special medical student component society of the Indiana State Medical Association; and be it further

Resolved, That in establishing such a society the appropriate Commission of the Association work in conjunction with representatives of the medical student-body to formulate suggested guidelines for the accomplishment of the intent of this resolution, and report back to the 1978 House of Delegates.

Resolution No. 77-37

Introduced by: Fort Wayne-Allen County Medical Society

Subject: UNSOLICITED MULTIPHASIC SCREENING RESULTS

ACTION: Adopted.

Whereas, There is a need for the Indiana State Medical Association to initiate legislation to hold physicians harmless from obligation to interpret and followup unsolicited laboratory testing; and

Whereas, Such legislation should require the testing laboratory to be held responsible for proper follow-up of all such test findings; now, therefore, be it

Resolved, That such legislation be initiated and that the subject of mass multiphasic screening be referred to the appropriate Indiana State Medical Association committee for study of its efficacy, efficiency and costs.

Resolution No. 77-38

Introduced by: Fort Wayne-Allen County Medical Society

Subject: DUES ASSESSMENT

ACTION: Adopted as amended.

Whereas, The American Medical Association's financial condition has been vastly improved by careful spending and increased revenues; and

Whereas, A considered safe level of

\$60,000,000 in reserve will be attained within the next year; and

Whereas, The American Medical Association members who contributed the special \$60 assessment did much to pull the AMA through its period of financial peril; now, therefore, be it

Resolved, That these members be credited with \$60 toward their AMA dues the year following that time the American Medical Association treasury reaches an adequate reserve level.

Resolution No. 77-39

Introduced by: Fort Wayne-Allen County Medical Society

Subject: POLICY COUNCIL REPRESENTATION ON REFERENCE COMMITTEES

ACTION: Adopted as amended.

Whereas, The American Medical Association Council members have previously decided in their deliberations what a report, paper, study or resolution should contain, they may not serve open-mindedly if placed on a reference committee; and

Whereas, The American Medical Association House actions should always be a democratic process with room for free and open debate; now therefore, be it

Resolved, That the AMA House of Delegates establish a policy that no Council member may sit on a reference committee considering items referred to that committee by the Council of which he is a member.

Resolution No. 77-40

Introduced by: Fort Wayne-Allen County Medical Society

Subject: SURRENDER OF LICENSE UPON RETIREMENT AND ISMA MEMBERSHIP STATUS

ACTION: Adopted.

Whereas, Under the Medical Practice Law upon retirement from practice a physician must surrender his license; and

Whereas, Under the new ISMA Constitution and Bylaws a member whose license has been suspended or revoked shall not be entitled to any of the rights or benefits of ISMA or any of its components or take part in any of its proceedings; and

Whereas, There has been much confusion regarding membership status following the surrender of the license upon retirement; now, therefore, be it

Resolved, That the ISMA Bylaws be amended in the following manner:

Add to Division One, Chapter 1, Section 1, following "who hold an unrestricted license to practice medicine and surgery" a statement "unless the license has been surrendered because

of retirement as required in the Medical Practice Law," and

Division One, Chapter 1, Section 4, add at the end of Paragraph A, "This shall not apply to the physician who has surrendered his license because of retirement under the provisions of the Medical Practice Law."

Resolution No. 77-41

Introduced by: Fort Wayne-Allen County Medical Society
Subject: INTERFERENCE IN DOCTOR-PATIENT RELATIONSHIP (BLUE SHIELD AND THIRD PARTIES)

ACTION: Adopted.

Whereas, The Medical Necessity Program adopted by the Blue Shield Association seeks to control certain aspects of the practice of medicine; and

Whereas, Acceptance of this type of restriction could lead to additional curtailments of a physician's professional judgments in the management of his patients; and

Whereas, Hospital medical staffs survey the practice of medicine in their hospitals, thus eliminating the need for third party payers attempting to do this; now, therefore, be it

Resolved, That the Indiana State Medical Association oppose this unwarranted intervention into the doctor-patient relationship.

Resolution No. 77-42

Introduced by: Vanderburgh County Medical Society
Subjects: HONORARY MEMBERSHIP IN ISMA FOR ROBERT J. AMICK

ACTION: Adopted.

Whereas, On March 31, 1977, Robert J. Amick completed 25 years as a member of the staff of the Indiana State Medical Association; and

Whereas, Mr. Amick has served the physicians of Indiana honorably and well during the entire quarter century with I.S.M.A.; and

Whereas, He has worked vigorously to meet the challenges which have continuously confronted the association; now, therefore, be it

Resolved, That Mr. Amick's years of service and his dedication to medicine be recognized; and be it further

Resolved, That Robert J. Amick be elected an honorary member of the Indiana State Medical Association.

Resolution No. 77-43

Introduced by: Fountain-Warren County Medical Society

Subject: INFORMATION ON PRESCRIPTION LABELS

ACTION: Adopted.

Whereas, Better health care is the goal of all health professionals; and

Whereas, Many people keep medications for prolonged periods of time; and

Whereas, Many medications, with the passing of time, lose their potency or deteriorate, making them potentially harmful; now therefore be it

Resolved, That the Indiana State Medical Association through its good relations with the Pharmacy Association and its Commission on Legislation seek to require an expiration date on the prescription label for all drugs that have such dating.

Resolution No. 77-44

Introduced by: Dubois County Medical Society
Subject: ABORTION ON DEMAND

ACTION: Referred to Board of Trustees with counsel of the ISMA Commission on Legislation.

Whereas, Abortion is a timely, moral, controversial and yet a medical problem; and

Whereas, It is a scientific fact that human life begins at conception; and

Whereas, From the time of Hippocrates, physicians have been dedicated to the saving of human life; and

Whereas, It has been custom of the medical personnel in this area to refrain from performing abortions; and

Whereas, The United States Supreme Court has struck down our state laws prohibiting abortion; now, therefore, be it

Resolved, That the Dubois County Medical Society reiterate its time-honored stand against abortion on demand and request the Indiana State Medical Association to do the same and instruct our state and federal legislators to enact the necessary laws or constitutional amendments to protect the lives of all of our citizens from the time of conception to a natural death.

Resolution 77-45

Introduced by: Executive Committee
Subject: SUBSCRIPTION RATE FOR THE JOURNAL

ACTION: Adopted.

Whereas, that portion of ISMA member's dues allocated to support *The Journal* was increased by \$2.00 in 1974 to \$8.00 by action of the House of Delegates; and

Whereas, This was the amount of each member's dues determined to be

appropriate for allocating subscription income prior to implementation of new IRS tax regulations pertaining to unrelated business income tax; therefore, be it

Resolved, That for purposes of budget projections and interim non-audited financial reports to the officers and membership, the amount of allocation from the General Fund be changed from \$8.00 to the actual net cost per member as determined at the end of the fiscal year; and be it further

Resolution, That the subscription rates charged to non-dues-paying members be consistent with the amount allocated from each member's dues.

Resolution 77-46

Introduced by: Executive Committee
Subject: TRANSFER OF MEDICAL DEFENSE FUND TO GENERAL FUND

ACTION: Adopted.

Whereas, The Medical Defense Fund was established September 1926, as a designated fund; and

Whereas, Sound accounting practices dictate that this Fund be transferred to the General Fund to facilitate flexibility in responding to future demands that may be placed on the Association; and

Whereas, ISMA auditors recommended this action following last year's audit; and

Whereas, The benefits to members under the program will continue to be available; therefore be it

Resolved, That the Medical Defense Fund no longer be handled as a designated fund and that it be transferred to the General Fund and that the Bylaws be so amended.

Resolution 77-47

Presented by: James A. Harshman, M.D., Chairman
Subject: APPOINTMENT OF COMMITTEE ON NEGOTIATIONS

ACTION: Adopted as amended and referred to the Commission on Constitution and Bylaws (Further Reference: Report of Ad Hoc Committee on Arbitration; Board of Trustees' Report M, Negotiations)

Whereas, ISMA Resolutions 76-4, 76-6 and 76-10 requested the Board of Trustees to study the role of ISMA in collective bargaining and fee mediations; and

Whereas, The president of the Association appointed an Ad Hoc Committee on Arbitration to study and make recommendations to the Board of Trustees and the House of Delegates; and

Whereas, The Ad Hoc Committee an Arbitration has met several times during the year to carry out the directive of

the House and has formulated a series of recommendations for consideration by the House of Delegates; now, therefore be it

Resolved, That these recommendations be submitted to the House of Delegates for their consideration, as follows:

1. That a Committee on Arbitration and Negotiation be created by the Board of Trustees;
2. That the name of the committee be Committee on Arbitration and Negotiation;
3. That the committee consist of a limited number of physicians (possibly six or more);
4. That membership on the committee be for four years (terms to consist of two years each) with initial nominations staggered to permit continuity of service;
5. That the committee may become involved in but not limited to negotiating with third parties and various governmental agencies upon specific direction from the Board of Trustees;
6. That the committee should be prepared to act instead of react to proposals which affect the practice of medicine;
7. That at the present time one of the purposes of the committee is to be planning, investigative and educative to our membership.

Resolution 77-48

Presented by: Future Planning Committee
Subject: COMPUTER APPLICATIONS FOR ISMA

ACTION: Referred to Board of Trustees for consideration. (Further reference: Resolution 77-33 and Report of Commission on Medical Services; Report S, Board of Trustees)

Whereas, The Future Planning Committee of the Indiana State Medical Association has during the past year studied in depth the potential of computer applications relative to the practice of medicine; and

Whereas, If the ISMA is to remain a major and viable spokesman for all physicians in Indiana it is necessary that a plan be developed to formulate a physician and patient data bank; and

Whereas, The Board of Trustees of the ISMA has also expressed interest in the development of a system for obtaining ideas and feelings of Indiana physicians rapidly and accurately in order to facilitate knowledgeable decision making; now, therefore be it

Resolved, That the House of Delegates endorse the continuation of pursuing concepts embraced in the 1977 Computer Feasibility Study.

Resolution No. 77-49

Introduced by: Marshall County Medical Society
Subject: ISMA DISTRICT RESTRUCTURING
ACTION: Substitute Resolution 77-49 Adopted.

Resolved, That a possible redistricting plan be investigated and studied by the Future Planning Committee.

Resolution No. 77-50

Introduced by: Vanderburgh County Medical Society
Subject: PARTICIPATION IN ISMA GROUP HEALTH CARE PLAN
ACTION: Adopted.

Whereas, Members of the Indiana State Medical Association and their widows have access to a group health care plan intended as a benefit to members and their families and is, in fact, a benefit which is especially valued by many; and

Whereas, Access to such a plan has acted as an inducement to membership for some; and

Whereas, Physicians are permitted to enroll in the plan upon application for ISMA membership; and

Whereas, Not all applicants are approved, nor do all members necessarily retain ISMA membership throughout their lifetimes; and

Whereas, Indiana Blue Cross-Blue Shield does not at present purge the list of these policyholders who are not approved for membership, or whose membership has lapsed; now, therefore, be it

Resolved, That ISMA work with Blue Cross-Blue Shield to develop a procedure which will regularly update membership to insure that participation in the ISMA group plan is contingent on continued membership in ISMA, except that widows of physicians whose membership was current at the time of their demise shall continue to have access to the plan.

Resolution No. 77-51

Introduced by: Fayette-Franklin County Medical Society
Subject: THIRD PARTY PAYMENTS FOR ALL THE PHYSICIANS IN INDIANA

ACTION: Referred to Board of Trustees for resubmission to 1978 House of Delegates.

Whereas, At present there exists discrimination in payment scale by third party payors to small town and rural physicians, compared to physicians in metropolitan areas, which in turn in-

hibits physician recruitment; now, therefore, be it

Resolved, That ISMA go on official record that every physician in Indiana be compensated at the same rate for the same service.

Resolution No. 77-52

Introduced by: Ross L. Egger, M.D.
Subject: INSTRUCTION IN CPR IN ACCREDITED SCHOOLS
ACTION: Adopted.

Whereas, a significant reduction in deaths due to coronary artery disease has been effected when significant numbers of the lay public become certified in CPR; and

Whereas, it has been shown that children from the sixth grade up can effectively learn CPR; now, therefore, be it

Resolved, That the Indiana State Medical Association recommend to the Indiana Department of Public Instruction that Basic Cardiac Life Support (CPR), according to the Standards of the American Heart Association, be required in the curriculum of all accredited secondary Indiana schools.

Resolution No. 77-53

Introduced by: Ross L. Egger, M.D.
Subject: INSTRUCTION IN CPR FOR PHYSICIANS
ACTION: Adopted.

Whereas, over 664,854 deaths occur annually from coronary artery disease; and

Whereas, over 40% of those could be revived with appropriate CPR; and

Whereas, few licensed physicians have had instructions in CPR as a part of their graduate medical education; and

Whereas, the American Heart Association has developed and widely utilized an effective, brief instructional package on CPR; now, therefore, be it

Resolved, that the Indiana State Medical Association and the American Medical Association recommend that all licensed physicians become proficient in CPR according to the Standards of the American Heart Association; and be it further

Resolved, that the Indiana State Medical Association and the American Medical Association recommend that all licensed physicians working in critical care areas become proficient in Advanced Cardiac Life Support according to the Standards of the American Heart Association.

Resolution No. 77-54

Introduced by: Paul Honan, M.D.
Section on Ophthalmology and Otolaryngology

Subject: DIFFERENTIAL PAY-
MENT PLANS

AND

Resolution No. 77-56

Introduced by: Delaware - Blackford
County Medical Society
Subject: DIFFERENTIAL PAY-
MENT FOR MEDICAL
SERVICES

ACTION: Substitute resolution amended
and adopted in lieu of Resolutions 77-54
and 77-56.

Resolved, That it be the policy of
Indiana State Medical Association to op-
pose all arrangements whereby there is
a discriminatory feature for participating
and nonparticipating physicians; and be
it further

Resolved, That under third-party pay-
ment programs it is in the interest of the
preservation of the covered patients'
rights to free choice of physicians that
there be no differential on the amount
paid for the provision of a covered
service by a "participating" physician
and the amount paid for the provision of
the same service by a "nonparticipating"
physicians; and be it further

Resolved, That ISMA urge the Indiana
State Insurance Commissioner to prohib-
it the issuance of any health insurance
policy in the State of Indiana which
discriminates against any patient, by
providing a higher fee for patients of a
participating physician, and a lower fee
for patients of a nonparticipating phy-
sician; and be it further

Resolved, That ISMA urge all state
medical societies, AMA, and other in-
terested professions to support the
promulgation of this ideal to the respec-
tive state insurance commissioners; and
be it further

Resolved, That ISMA use its influence
and staff to assist in the preparation and
passage of legislation to implement the
above philosophy by legally preventing
the issuing and sale of health insurance
in the State of Indiana, which discrimi-
nates against the patients of non-
participating physicians by allowing less
benefits for services rendered on their
behalf by a nonparticipating physician
than would be allowed for similar serv-
ices rendered by a participating physi-
cian; and be it further

Resolved, That in the event that a suit
is brought challenging such differential
payment, the House authorizes the Board
to file an amicus curiae brief in support
of such challenge.

Resolution No. 77-55

Introduced by: Marion County Medical
Society
Subject: AMA SUPPORT OF
THE AMERICAN
BLOOD COMMISSION

ACTION: Adopted.

Whereas, The American Medical As-
sociation is in firm agreement with the
goals of the National Blood Policy as
delineated by the Secretary of Health,
Education, and Welfare; and

Whereas, The American Medical As-
sociation believes the private sector to be
responsible for the development of such
a program; and

Whereas, The American Medical As-
sociation assumed a leadership role in
organizing the American Blood Commis-
sion for this purpose; therefore be it

Resolved, That the American Medical
Association continue to play an affirma-
tive leadership role in the activities of
the American Blood Commission and in
the formulation and implementation of
the National Blood Program.

Resolution No. 77-56

Introduced by: Delaware - Blackford
County Medical Society
Subject: DIFFERENTIAL PAY-
MENT FOR MEDICAL
SERVICES
AND

Resolution No. 77-54

Introduced by: Paul Honan, M.D.
Section on Ophthalmol-
ogy and Otolaryngology
Subject: DIFFERENTIAL PAY-
MENT PLANS

ACTION: Substitute resolution amended
and adopted in lieu of Resolutions 77-56
and 77-54 (Refer to Resolution 77-54).

Presidential Resolution

ACTION: Adopted by Acclamation.

Whereas, This year's expanding affairs
of the Indiana State Medical Association
have added to the already heavy com-
mitment for its president; and

Whereas, He has executed those com-
mitments—plus others of established
nature—in an exemplary manner; and

Whereas, This has been accomplished,
in many respects, at great sacrifice by
his family and himself, and;

WHEREAS, He has caused great
progress in the areas of arbitration and
policing our own, in addition to aiding
the progress of established programs of

benefit to the association; now therefore,
be it

Resolved, That the sincere thanks and
appreciation of this House of Delegates,
during the 128th annual convention of
this Association, be expressed in the
name of all Association members, to
John W. Beeler, M.D., for his laudable
year as President of the Indiana State
Medical Association.

Resolution to Staffs and Others

ACTION: Adopted by Acclamation.

Whereas, it takes the cooperation and
hard work of many groups to put on a
successful convention; and

Whereas, this 128th Annual Con-
vention has proven to be very rewarding and
extremely well handled through the co-
operation of the Indiana State Medical
Association staff and Commission on
Convention Arrangements, Hyatt Regen-
cy Indianapolis staff, Indianapolis Con-
vention Bureau personnel, and State
Board of Health; and

Whereas, a financial contribution has
been received from Bristol Laboratories,
CIBA Pharmaceutical Company, Immke
Circle Leasing, Inc., Eli Lilly and Com-
pany, Mead Johnson Laboratories, the
Medical Protective Company, Merck
Sharp & Dohme, Parke, Davis & Com-
pany, Professional Management, A. H.
Robins Company, Schering Corporation,
Searle Laboratories, E. R. Squibb & Sons,
Inc., The Upjohn Company and Wyeth
Laboratories to assist with the educa-
tion program at the Convention; now,
therefore, be it

Resolved, that this House of Delegates
extend its deep appreciation to the ISMA
staff and Commission on Convention
Arrangements; and, be it further

Resolved, that this House also extend
thanks to the Hyatt Regency staff, In-
dianapolis Convention Bureau, State
Board of Health and all those who con-
tributed to the successful educational
program during the 1977 Convention.

Place of Future Annual Conventions

1978 - Clarksville - October 21-25

1979 - Indianapolis - October 8-10

1980 - Indianapolis - dates to be set by
Board of Trustees

1981 - Indianapolis - dates to be set by
Board of Trustees

1982 - Indianapolis - dates to be set by
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Adjournment

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"The best thing to give your enemy is forgiveness; your opponent—tolerance; your friend—your heart; your child—a good example; your father—deference; your mother—conduct designed to make her proud of you; yourself—respect; to all men—charity."

To One and All, Best Wishes for Christmas and the New Year from the editor and staff of The Journal.

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of the
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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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